DOWNLOAD PDF UNDERSTANDING AND TREATING DEPRESSED ADOLESCENTS AND THEIR FAMILIES

Chapter 1 : - NLM Catalog Result

Primarily a clinical book on treating adolescent depression, with various treatment strategies tied closely to the understanding of etiology, dynamics and assessment of the depressed adolescent patient, all within a family systems orientation.

Withdrawal from friends and family Loss of interest in activities Poor school performance Changes in eating and sleeping habits Restlessness and agitation Feelings of worthlessness and guilt Lack of enthusiasm and motivation Fatigue or lack of energy Difficulty concentrating Thoughts of death or suicide Depression in teens vs. The following symptoms are more common in teenagers than in their adult counterparts: Irritable or angry mood. As noted, irritability, rather than sadness, is often the predominant mood in depressed teens. A depressed teenager may be grumpy, hostile, easily frustrated, or prone to angry outbursts. Unexplained aches and pains. Depressed teens frequently complain about physical ailments such as headaches or stomachaches. If a thorough physical exam does not reveal a medical cause, these aches and pains may indicate depression. Extreme sensitivity to criticism. Depressed teens are plagued by feelings of worthlessness, making them extremely vulnerable to criticism, rejection, and failure. While adults tend to isolate themselves when depressed, teenagers usually keep up at least some friendships. However, teens with depression may socialize less than before, pull away from their parents, or start hanging out with a different crowd. Hormones and stress can explain the occasional bout of teenage angstâ€”but not continuous and unrelenting unhappiness, lethargy, or irritability. Suicide warning signs in depressed teens Seriously depressed teens, especially those who also abuse alcohol or drugs, often think about, speak of, or make attempts at suicideâ€”and an alarming and increasing number are successful. For hour suicide prevention and support in the U. To find a suicide helpline outside the U. To learn more about suicide risk factors, warning signs, and what to do in a crisis, read Suicide Prevention. If you suspect that your teen is depressed, bring up your concerns in a loving, non-judgmental way. Then ask your child to share what he or she is going throughâ€”and be ready and willing to truly listen. How to communicate with a depressed teen Focus on listening, not lecturing. Resist any urge to criticize or pass judgment once your teenager begins to talk. The important thing is that your child is communicating. Be gentle but persistent. Talking about depression can be very tough for teens. Simply acknowledging the pain and sadness they are experiencing can go a long way in making them feel understood and supported. If your teen claims nothing is wrong but has no explanation for what is causing the depressed behavior, you should trust your instincts. The important thing is to get them talking to someone. Helping a depressed teen tip 1: Encourage social connection Depressed teens tend to withdraw from their friends and the activities they used to enjoy. But isolation only makes depression worse, so do what you can to help your teen reconnect. Make face time a priority. Do what you can to keep your teen connected to others. Encourage them to go out with friends or invite friends over. Participate in activities that involve other families and give your child an opportunity to meet and connect with other kids. Get your teen involved. While your teen may lack motivation and interest at first, as they reengage with the world, they should start to feel better and regain their enthusiasm. Doing things for others is a powerful antidepressant and self-esteem booster. If you volunteer with them, it can also be a good bonding experience. Make physical health a priority Physical and mental health are inextricably connected. Depression is exacerbated by inactivity, inadequate sleep, and poor nutrition. Unfortunately, teens are known for their unhealthy habits: But as a parent, you can combat these behaviors by establishing a healthy, supportive home environment. Get your teen moving! Exercise is absolutely essential to mental health , so get your teen activeâ€”whatever it takes. Think outside the box: Set limits on screen time. Teens often go online to escape their problems, but when screen time goes up, physical activity and face time with friends goes down. Both are a recipe for worsening symptoms. Provide nutritious, balanced meals. Make sure your teen is getting the nutrition they need for optimum brain health and mood support: Encourage plenty of sleep. Teens need more sleep than adults to function optimallyâ€”up to hours per

night. No one therapist is a miracle worker, and no one treatment works for everyone. Talk therapy is often a good initial treatment for mild to moderate cases of depression. Therapy, Medication, and Lifestyle Changes Unfortunately, some parents feel pushed into choosing antidepressant medication over other treatments that may be cost-prohibitive or time-intensive. In all cases, antidepressants are most effective when part of a broader treatment plan. Medication comes with risks Antidepressants were designed and tested on adults, so their impact on young, developing brains is not yet fully understood. Some researchers are concerned that exposure to drugs such as Prozac may interfere with normal brain developmentâ€”particularly the way the brain manages stress and regulates emotion. They are also known to increase the risk of suicidal thinking and behavior in some teenagers and young adults. The risk of suicide is highest during the first two months of antidepressant treatment. Teenagers on antidepressants should be closely monitored for any sign that the depression is getting worse.

Chapter 2 : Your Adolescent - Anxiety and Avoidant Disorders

Understanding and treating depressed adolescents and their families 1 edition By Gerald D. Oster Understanding and treating depressed adolescents and their families.

You might at first encounter resistance from your teenager, but if you get therapy sessions started, you and your child might see tremendous benefits. But the pros outweigh the cons, both for your family in general, and for the development of your child. If your teen is resistant, you might let them know that he or she has choices. There are variety forms of depression treatment, including psychotherapy, medication therapy, group therapy, family therapy, and art therapy. Psychotherapy is essentially the opportunity for a teen to discuss his or her feelings with one person who is trained to listen and treat symptoms of depression. Psychotherapy can help a teenager manage his or her moods. If your child has been diagnosed with depression, a therapist can work with your child on specific mood managing techniques where medication might fall short. This treatment form is commonly used to treat teen depression. CBT essentially aims to change behavior by identifying negative and distorted thinking patterns. This successful form of therapy emphasizes the link between thoughts, feelings, and behavior, and more importantly, it attempts to identify the way that certain thoughts contribute to the unique problems of your life. By changing the thought pattern and by replacing it with thoughts that are aimed towards a specific therapeutic goal, you can slowly begin to change. Medication Therapy is the use of psychotropic medication to treat teen depression. Types of medication include antidepressants, antipsychotics, psycho-stimulants, anxiolytics, mood stabilizers, and central nervous system depressants. Of course, medication often comes with side effects. Therefore, finding the right drug at the right dosage is an important step in making this treatment form effective. Group therapy includes the presence of a therapist, psychologist, social worker or other mental health professional that is facilitating the group experience. Also in the room are others who are all experiencing the same diagnosis or life problem. For instance, adults who were sexually abused as children might make up a group in therapy. Typically, everyone in the room, aside from the therapist, is experiencing the same life challenge. Group therapy for teens with Bipolar Disorder can be incredibly supportive and healing. Family Therapy focuses on the systems and relationships within a family network. It aims to change the relationship within families in order to help them better manage the specific problems they might be facing. This form of therapy is used with a wide range of mental illnesses and is based on two principles: Many mental illnesses are made worse by the dysfunctions present in families. Close family members are often the supports that an individual suffering from mental illness has and are therefore extremely important in treatment. Art therapy is a form of treatment that uses creativity as a means to express feelings and thoughts. Rather, than talking which is deeply associated with social norms, expressing oneself creatively can allow the expression of what a teen might otherwise not be able to say. Expressing through art activates a different part of the brain that speaks a different language. Plus, as teens are navigating the terrain of adolescence, art therapy can be particularly useful as their brain continues to develop. The above listed therapies are commonly used to treat depression. In a national study conducted by the Centers for Disease Control, 61 percent of 8th to 10th graders reported feeling sad and hopeless, 36 percent reported nothing to look forward to, and 34 percent expressed serious thoughts of committing suicide. These are significant findings. Yet, if teens can find their way to therapy, they can turn their lives around.

Chapter 3 : Gerald D. Oster | LibraryThing

Primarily a clinical book on treating adolescent depression, with various treatment strategies tied closely to the understanding of etiology, dynamics and assessment of the depressed adolescent.

Page and involvement in individual therapy while attending group therapy Follette et al. This study used a randomized design to demonstrate that group therapy was significantly effective relative to a waiting-list control condition for adult survivors of incest and that treatment gains were maintained at a six-month follow-up. Differential benefits of different types of group therapy were also identified, with the more structured format providing more anxiety relief and the less structured interpersonal groups providing more opportunities for interpersonal learning and improved social adjustment Alexander et al. Future research on the treatment of adult survivors should pay particular attention to operationally defining moderating and mediating variables, clearly describing treatment methods, employing a broad range of outcome measures, using control or comparison groups, and administering follow-up assessments Alpert, A developmental approach also needs to be integrated in such research, as the value of particular forms of therapy may vary at different stages of recovery Alpert, Treatment for Adult Sex Offenders The treatment of child molesters is a controversial issue. Treatment programs are frequently offered to adult and adolescent offenders as part of plea bargaining negotiations in criminal prosecutions. The traditional assumption has been that children and society are better protected by offender treatment than by traditional prosecution and incarceration if the treatment service is effective Finkelhor et al. However, there is currently considerable debate about whether child molesters can be effectively treated. The most common approaches to treating child molesters are comprehensive treatment programs aimed at simultaneously treating multiple aspects of deviant sexual behavior. These programs usually incorporate educational approaches, behavior therapy, and relapse prevention Prentky, Group therapy, widely used in the treatment of pedophiles, allows patients with similar problems to share experiences, confront their behaviors, and understand motivations that govern sexual acts against children Langevin, Its primary purpose is to identify and confront cognitive distortions, rationalizations, excuses for offending, and behaviors that signal potential reoffending Salter, However, the lack of controlled studies, the difficulties of comparisons between studies using different and sometimes contradictory techniques, and the lack of replication complicate assessment of the value of group therapy in treating child molesters Crawford, Page Share Cite Suggested Citation: Understanding Child Abuse and Neglect. The National Academies Press. First developed in the treatment of addictive behaviors, such as substance abuse, relapse prevention was adapted for use with sex offenders to reduce the risk of re-offending Marques, ; Laws, ; Pithers, Although many different approaches to the treatment of sexual offenders have been tried including group therapy, family systems treatment, chemical interventions, and relapse prevention , scientific data indicating sustained reductions in recidivism are not available Becker, Most studies follow offenders only for one year after treatment, and it is not known if treatments are effective in eliminating molestation behavior beyond that period. Adolescent Sex Offenders Until recently, adolescent sexual offenders have been neglected in clinical and research literature, and empirically tested models to explain why adolescents commit sexual crimes or develop deviant sexual interest patterns are minimal Becker, The components and goals of treatment for adolescent sex offenders are similar to those involved in the treatment of adult sex offenders. In general, the treatment of adolescent sex offenders focuses more on family contexts and less on behavioral and chemical techniques such as aversive conditioning and chemical interventions Knopp et al. Preliminary outcome data on the treatment of juvenile sex offenders show positive outcomes Kavoussi et al. However, the National Adolescent Perpetrator Network established in has called attention to the lack of substantive research in the field and the lack of consensus regarding basic principles of treatment National Adolescent Perpetrator Network, Studies that employ standardized measures of treatment outcomes and long-term follow-ups on homogeneous samples are likely to be revealing about the effectiveness of

treatment for this population Kavoussi et al. Self-Help Services for Abusive Adults Self-help support and treatment programs are based on the premise that individuals can benefit from learning about the victimization experiences of others. These programs have attracted popular support in a wide range of health services, including the treatment of alcoholism, weight loss, and rape counseling programs, and they have also been applied in the treatment of both physically and sexually abusive adults. A self-help component has also been integrated into treatment programs for intrafamilial sexual abuse Giaretto, Parents United had active chapters in the United States and Canada in , which included self-help groups for the incest offender, the nonoffending spouse, children, and adults molested as children. Other groups similar to Parents Anonymous and Parents United are continually being formed. Few empirical studies with reliable outcome measures have been used to evaluate the effectiveness of individual self-help programs or to identify the characteristics of individuals who are most likely to benefit from such efforts. A comparison study of self-help groups conducted by Berkeley Planning Associates found that self-help groups and lay therapists were reliable predictors for reduced recidivism Cohn, One evaluation of Parents Anonymous, conducted by Behavior Associates, found that physical abuse stopped after one month of attendance and verbal abuse showed a significant decrease after two months of attendance Ehresman, Family-Oriented Interventions Most treatment interventions for physical abuse, child neglect, and emotional abuse seek to change parents or the home environment. Contemporary parent training programs focus on improving cognitive-behavioral skills and usually adapt behavioral methods designed originally to assist non-abusive families with behaviorally disturbed children Wolfe, Family systems treatments target the psychodynamic interplay in relationships in families. Intensive home-based services and family preservation services directly correspond to ecological, developmental theories of maltreatment and provide services directed at the overall needs of abusive families. A lack of consensus still exists regarding the effectiveness of a wide range of treatment services for maltreating families Azar and Wolfe, ; Isaacs, Outcome studies have indicated positive behavioral and attitudinal changes as a result of family or parent treatment, but few studies have examined the effects of such interventions on subsequent reports of child abuse and neglect beyond one year. Research in this area is dominated by single-case studies. Group studies that have been used are often characterized by a lack of random assignment to treatment conditions, small sample sizes, and inappropriate comparison groups Kaufman, Parental Enhancement Most parental enhancement programs focus on training abusive parents in child management e. Programs for neglectful parents typically focus on areas such as nutrition, homemaking, and child care. Parental enhancement programs may help some families who experience child management problems when a sexually abusive father is removed from the home. In these cases, child management skills help develop positive child-parent interaction in sexually abusive families. The efficacy of parent-training approaches for physically abusive parents has been supported by various single-case studies, one study using repeated measures, and group design studies Azar and Twentyman, ; Crimmins et al. Studies of multiple approaches and diverse populations have provided consistent evidence that parents can acquire behavioral skills and use them in interactions with their children, at least in clinical settings Golub et al. Some evidence suggests that training has reduced parental distress or symptomatology and, in some instances, improved child functioning Wolfe et al. Therapeutic directions highlight the need to incorporate diverse skills and to evaluate the effectiveness of individual approaches see Azar and Wolfe, Following an in-depth assessment, parents participate in customized programs including the use of groups, behavioral methods, and parental aides to offer specialized services including parent-child relations, home safety, nutrition and health maintenance, assertiveness training, job placement and vocational skills training, stress reduction training, alcoholism Page Share Cite Suggested Citation: Positive findings from single-subject case reports, reports of clients attaining treatment goals in the majority of cases, and lower recidivism rates for program clients compared with controls for a five-year period of program evaluation support this approach to family treatment Lutzker, ; Luztker and Rice, However, no comparison data were collected, and client assignment to Project Ways was not random. Evidence also suggests that treatment gains are not maintained when compared with a comparison group Wesch and Lutzker,

At present, few definitive studies demonstrate the efficacy of parent training in reducing re-abuse. Evaluations of the clinical impact of intervention on subsequent re-abuse recidivism rates and child and family functioning are needed Kolko, in press. The severity of family dysfunction evident in some cases of abuse or neglect may also limit the applicability of parent-training methods. Family Systems Treatment Family systems treatment, commonly used in the treatment of intrafamilal sexual abuse, seeks to change the psychosocial interactions among family members. Clinical descriptions of family therapy combined with individual and group therapy suggest its potential usefulness for families who are highly dysfunctional, although controlled evaluations of family therapy in child sexual abuse have not been conducted Alexander, ; Bentovim and Van Elburg, ; Giaretto, , ; Ribordy, ; Sgroi, ; Walker et al. Some programs have indicated a recidivism rate as low as 3 percent Anderson and Shafer, Home-Based Services and Family Preservation Services Home-based services and family preservation services address the overall needs of families, include both children and parents, and focus directly on contextual factors, such as poverty, single parenthood, and marital discord, that increase stress, weaken families, and elicit aggressive behavior Kolko, in press. These programs target functional relationships among diverse individual, family, and systemic problems by combining traditional social work with various therapeutic counselling approaches. The use of home-based services has been advocated in response to the multiple problems found among abusive and neglectful families, difficulties in providing services in a traditional format, and interests in reducing the number of children placed in foster care. The breadth of potential family dysfunction has encouraged hands-on approaches that address risk factors at Page Share Cite Suggested Citation: Applications of the home-based approach in child maltreatment have become increasingly popular in recent years. Studies of home-based services have found that a multisystemic approach using multiple treatment modalities resulted in greater improvements in parent-child relationships and child behavior problems than simple parent training in child management skills Brunk et al. However, the generalizability of these findings is limited by methodological problems, including the absence of clear targets for certain conditions Nichol et al. Home-based approaches have demonstrated particular effectiveness with neglectful families Daro, The crisis conditions of some neglectful families, including poverty at the time of the report of neglect, have sometimes been described as the most recent manifestation of a deeply troubled history of the offending parent Polansky et al. Family preservation programs are designed to prevent the placement of children outside the home while ensuring their safety. Family preservation services are often characterized by their intensity hours per week , short duration often 6 weeks , and their flexibility in providing a range of therapeutic and support services tailored to the needs of families in crisis. Family preservation programs are often designed to address multiple goals, including the protection of children, strengthening family bonds, providing stability in crisis situations, increasing family skills and competencies, fostering family use of formal and informal helping resources, and preventing unnecessary out-of-home placement of children Tracy et al. The Homebuilders program Kinney et al. The Homebuilders model is notable for its individualized interventions, program intensity, flexible schedule, small caseloads, goal orientation, time limited services, and program evaluation efforts Whittaker et al. Individual programs vary by such factors as method of operation drawing on public agency staff or private contracts , level of training, availability of staff, and availability of funds to purchase goods or services for families Kammerman and Kahn, The majority of children remain at home following service termination or at follow-up. However, the effectiveness of family preservation services remains unclear because most evaluative studies have suffered from methodological problems such as small samples, little reliability with respect to validity of measures, and nonexperimental designs Kinney et al. Research on family preservation services is also complicated by variations in definitions of outcome, the target population, and the quality of services Wells and Biegel, These studies have revealed equivocal findings about the effectiveness of family preservation programs, including high placement avoidance rates in control groups Feldman, ; Mitchell et al. It is likely that mixing clients of different ages, problem types, referral sources, and service domains has weakened the findings of studies. One recent study evaluated outcomes of family preservation services in different subpopulations of a relatively

large sample within one service domain. Significant differences were found between families experiencing different types of maltreatment: Despite equivocal evidence of long-term effectiveness, family preservation services are currently believed to be a cost-effective alternative to the institutionalization or foster care placements for many children.

Chapter 4 : Teen depression - Symptoms and causes - Mayo Clinic

Finally, children and adolescents are affected by their families. Parental vulnerabilities, family stresses, and family conflicts all may exacerbate problems and hamper treatment, if not addressed. It is also important to note that because depression and mood disorders appear to run in families that depressed teens and children may have one or.

It is a natural and important emotion, signaling through stirrings of worry, fearfulness, and alarm that danger or a sudden, threatening change is near. Yet sometimes anxiety becomes an exaggerated, unhealthy response. Given the array of changes and uncertainties facing a normal teenager, anxiety often hums along like background noise. For some teenagers, anxiety becomes a chronic, highpitched state, interfering with their ability to attend school and to perform up to their academic potential. Participating in extracurricular activities, making and keeping friends, and maintaining a supportive, flexible relationship within the family become difficult. Sometimes anxiety is limited to generalized, free-floating feelings of uneasiness. At other times, it develops into panic attacks and phobias. Identifying the Signs Anxiety disorders vary from teenager to teenager. Symptoms generally include excessive fears and worries, feelings of inner restlessness, and a tendency to be excessively wary and vigilant. Even in the absence of an actual threat, some teenagers describe feelings of continual nervousness, restlessness, or extreme stress. In a social setting, anxious teenagers may appear dependent, withdrawn, or uneasy. They seem either overly restrained or overly emotional. They may be preoccupied with worries about losing control or unrealistic concerns about social competence. Teenagers who suffer from excessive anxiety regularly experience a range of physical symptoms as well. They may complain about muscle tension and cramps, stomachaches, headaches, pain in the limbs and back, fatigue, or discomforts associated with pubertal changes. They may blotch, flush, sweat, hyperventilate, tremble, and startle easily. When flooded with anxiety, adolescents may appear extremely shy. They may avoid their usual activities or refuse to engage in new experiences. They may protest whenever they are apart from friends. Or in an attempt to diminish or deny their fears and worries, they may engage in risky behaviors, drug experimentation, or impulsive sexual behavior. Panic Disorder More common in girls than boys, panic disorder emerges in adolescence usually between the ages of fifteen and nineteen. Feelings of intense panic may arise without any noticeable cause or they may be triggered by specific situations, in which case they are called panic attacks. A panic attack is an abrupt episode of severe anxiety with accompanying emotional and physical symptoms. Accompanying the emotional symptoms may be shortness of breath, sweating, choking, chest pains, nausea, dizziness, and numbness or tingling in his extremities. Following a panic attack, many youngsters worry that they will have other attacks and try to avoid situations that they believe may trigger them. Because of this fearful anticipation, the teen may begin to avoid normal activities and routines. Phobias Many fears of younger children are mild, passing, and considered within the range of normal development. Some teenagers develop exaggerated and usually inexplicable fears called phobias that center on specific objects or situations. The fear generated by a phobia is excessive and not a rational response to a situation. The objects of a phobia usually change as a child gets older. Several studies have revealed an increase in school avoidance in middle-school or junior-high years. With school avoidance, excessive worries about performance or social pressures at school may be at the root of the reluctance to attend school regularly. This leads to a cycle of anxiety, physical complaints, and school avoidance. The cycle escalates with the worsening of physical complaints such as stomachaches, headaches, and menstrual cramps. Visits to the doctor generally fail to uncover general medical explanations. The longer a teenager stays out of school, the harder it becomes for him to overcome his fear and anxiety and return to school. He feels increasingly isolated from school activities and different from other kids. Some youngsters are naturally more timid than others, As their bodies, voices, and emotions change during adolescence, they may feel even more self-conscious. Despite initial feelings of uncertainty, most teens are able to join in if given time to observe and warm up. He may deal with his social discomfort by fretting about his health, appearance, or overall competence. Alternatively, he may

behave in a clowning or boisterous fashion or consume alcohol to deal with the anxiety. Some teens with social phobia may try to sidestep their anxious feelings altogether by refusing to attend or participate in school, Classroom and academic performance falls off, involvement in social and extracurricular activities dwindles, and, as a consequence, self-esteem declines. Some teens may experience such a high level of anxiety that they cannot leave the house. This disorder, agoraphobia, seems to stem from feelings about being away from parents and fears of being away from home rather than fear of the world. In fact, a number of children who demonstrate severe separation anxiety in early childhood go on to develop agoraphobia as adolescents and adults. Causes and Consequences Most researchers believe that a predisposition towards timidity and nervousness is inborn. A cycle of increasing uneasiness may then be established. By the time this child reaches adolescence, his characteristic way of experiencing and relating to his world is tinged with anxiety. Some research suggests that children who are easily agitated or upset never learned to soothe themselves earlier in life. In many cases, adolescent anxiety disorders may have begun earlier as separation anxiety, the tendency to become flooded with fearfulness whenever separated from home or from those to whom the child is attached, usually a parent. Adolescents can also have separation disorders. These teens may deny anxiety about separation, yet it may be reflected in their reluctance to leave home and resistance to being drawn into independent activity. School avoidance can follow a significant change at school, such as the transition into middle school or junior high. It may also be triggered by something unrelated to school, such as a divorce, illness, or a death in the family. Some youngsters become fearful about gang activities or the lack of safety in school. A worried teenager performs less well in school, sports, and social interactions. A teen who experiences a great deal of anxiety may be overly conforming, perfectionistic, and unsure of himself. In attempting to gain approval or avoid disapproval, he may redo tasks or procrastinate. The anxious youngster often seeks excessive reassurance about his identity and whether be is good enough. Some teenagers with anxiety disorders can also develop mood disorders or eating disorders. Some teenagers who experience persistent anxiety may also develop suicidal feelings or engage in self-destructive behaviors; these situations require immediate attention and treatment. Anxious teens may also use alcohol and drugs to self-medicate or self-sootheor develop rituals in an effort to reduce or prevent anxiety. How to Respond If your teenager is willing to talk about his fears and anxieties, listen carefully and respectfully. Without discounting his feelings, help him understand that increased feelings of uneasiness about his body, performance, and peer acceptance and a general uncertainty are all natural parts of adolescence. By helping him trace his anxiety to specific situations and experiences, you may help him reduce the overwhelming nature of his feelings. Reassure him that, although his concerns are real, in all likelihood he will be able to handle them and that as he gets older, he will develop different techniques to be better able to deal with stress and anxiety. Remind him of other times when he was initially afraid but still managed to enter into new situations, such as junior high school or camp. Praise him when he takes part in spite of his uneasiness. Point out that you are proud of his ability to act in the face of considerable anxiety. Remember, your teenager may not always be comfortable talking about feelings that he views as signs of weakness. His doctor or teacher will be able to recommend a child and adolescent psychiatrist or other professional specializing in treating adolescents. Managing anxiety disorders - as with any adolescent emotional disturbance - usually requires a combination of treatment interventions. The most effective plan must be individualized to the teenager and his family. Treatment for an anxiety disorder begins with an evaluation of symptoms, family and social context, and the extent of interference or impairment to the teen. Parents, as well as the teenager, should be included in this process. The evaluating clinician will also consider any underlying physical illnesses or diseases, such as diabetes, that could be causing the anxiety symptoms. Medications that might cause anxiety such as some drugs used in treating asthma will be reviewed. Other biological, psychological, family, and social factors that might predispose the youngster to undue anxiety will also be considered. If a teenager refuses to go to school, a clinician will explore other possible explanations before labeling it school avoidance. Perhaps the teen is being threatened or harassed, is depressed, or has an unrecognized learning disability. He may also be skipping school in order to

be with friends, not from anxiety about performance or separation. If the teenager has engaged in suicidal or self-endangering behavior, is trying to self medicate through alcohol or drug use, or is seriously depressed, these problems should be addressed immediately. In such cases, hospitalization may be recommended to protect the youngster. If the problem manifests in school avoidance, the initial goal will be to get the youngster back to school as soon as possible. Cognitive-Behavioral Therapy In many cases, cognitive-behavioral psychotherapy techniques are effective in addressing adolescent anxiety disorders. Such approaches help the teenager examine his anxiety, anticipate situations in which it is likely to occur, and understand its effects. This can help a youngster recognize the exaggerated nature of his fears and develop a corrective approach to the problem. Other Therapies In some instances, long-term psychotherapy, and family therapy may also be recommended. Medications When symptoms are severe, a combination of therapy and medication may be used. Antidepressant medications, such as nortriptyline Pamelor , imipramine Tofranil , doxepin Sinequan , paroxetine Paxil , sertraline Zoloft , or fluoxetine Prozac , or anxiety-reducing drugs, such as alprazolam Xanax , clonazepam Klonopin , or lorazepam Ativan may be prescribed in combination with cognitive or other psychotherapy.

DOWNLOAD PDF UNDERSTANDING AND TREATING DEPRESSED ADOLESCENTS AND THEIR FAMILIES

Chapter 5 : Understanding and treating depressed adolescents and their families | Open Library

Depressed teens tend to withdraw from their friends and the activities they used to enjoy. But isolation only makes depression worse, so do what you can to help your teen reconnect. Make face time a priority.

Print Overview Teen depression is a serious mental health problem that causes a persistent feeling of sadness and loss of interest in activities. It affects how your teenager thinks, feels and behaves, and it can cause emotional, functional and physical problems. Although depression can occur at any time in life, symptoms may be different between teens and adults. Issues such as peer pressure, academic expectations and changing bodies can bring a lot of ups and downs for teens. For most teens, depression symptoms ease with treatment such as medication and psychological counseling. Emotional changes Be alert for emotional changes, such as: Feelings of sadness, which can include crying spells for no apparent reason Feeling hopeless or empty Frustration or feelings of anger, even over small matters Loss of interest or pleasure in normal activities Loss of interest in, or conflict with, family and friends Low self-esteem Feelings of worthlessness or guilt Fixation on past failures or exaggerated self-blame or self-criticism Extreme sensitivity to rejection or failure, and the need for excessive reassurance Trouble thinking, concentrating, making decisions and remembering things Ongoing sense that life and the future are grim and bleak Frequent thoughts of death, dying or suicide Behavioral changes Watch for changes in behavior, such as: Talk with your teen. Try to determine whether he or she seems capable of managing challenging feelings, or if life seems overwhelming. Talk to a health care provider such as your doctor or school nurse. Share your concerns with a parent, a close friend, a spiritual leader, a teacher or someone else you trust. When to get emergency help Suicide is often associated with depression. If you think you may hurt yourself or attempt suicide, call or your local emergency number immediately. Call your mental health specialist Call a suicide hotline number â€” in the U. Make sure someone stays with that person Call or your local emergency number immediately Or, if you can do so safely, take the person to the nearest hospital emergency room Never ignore comments or concerns about suicide. Always take action to get help. Neurotransmitters are naturally occurring brain chemicals that carry signals to other parts of your brain and body. When these chemicals are abnormal or impaired, the function of nerve receptors and nerve systems change, leading to depression. Depression is more common in people whose blood relatives also have the condition. Traumatic events during childhood, such as physical or emotional abuse, or loss of a parent, may cause changes in the brain that make a person more susceptible to depression. Learned patterns of negative thinking. Risk factors Many factors increase the risk of developing or triggering teen depression, including: Complications related to teen depression may include, for example: However, these strategies may help. Encourage your teenager to: Take steps to control stress, increase resilience and boost self-esteem to help handle issues when they arise Reach out for friendship and social support, especially in times of crisis Get treatment at the earliest sign of a problem to help prevent depression from worsening Maintain ongoing treatment, if recommended, even after symptoms let up, to help prevent a relapse of depression symptoms.

Chapter 6 : Understanding and Treating Depression and Mood Disorders in Children and Adolescents

Diabetic Adolescents and their Families presents an innovative approach to the study of coping with chronic illness by focusing on the developmental context in its description of a longitudinal study of families with a diabetic or a healthy adolescent.

For Bipolar Disorder, there is evidence that the rates for adolescents may be similar to that of adults ref. More recent estimates have suggested that the percentage of children and adolescents with depression and mood disorders may be on the increase. Research has found that early onset of bipolar disorder may be associated with a more severe form of the disorder ref. In addition, there is strong evidence to suggest that depression and mood disorders greatly increase the risk for suicide and suicidal behavior, particularly in adolescents ref. Finally, depression both Major Depressive disorder and Dysthymic disorder are associated with fewer friendships, lower levels of achievement academic and vocational and higher levels of stress ref. Increasingly, mental health professionals have recognized that depression and mood disorders have a strong inherited or genetic component. Studies have consistently found that depression and mood disorders particularly bipolar disorder run in families. Thus, it is not uncommon for a child or adolescent who is experiencing depression to have a parent or grandparent who has or is also diagnosed with depression or a mood disorder. In addition, there is evidence to suggest that stress, loss and trauma can place children and adolescents at risk for depression. Thus, if one believes that we are living in an increasingly stressful world, it is not surprising to conclude that more children and adolescents are at risk for depression. Diagnosis of Depression and Mood Disorders Diagnosing depression and mood disorders. Children and adolescents are often not good at clearly describing their symptoms. In addition, many children and adolescents do not clearly connect their behavior to their feelings. Thus, children may not feel depressed, but may act out, behave in negative ways, and experience non-specific physical complaints stomachaches and headaches , all of which may reflect a depression or mood disorder. The process of diagnosis is further complicated by the fact that children and adolescents can experience depression differently than adults. Rather, they may be irritable, complain about vague and non-specific aches and pains and act in disruptive or negative ways. While adolescents are more able to identify and describe their feelings, it is not uncommon for adolescents to experience depression differently than adults. Specifically, adolescents may experience an irritable mood rather than feeling depressed. In addition, they may be overly negative and cynical, adopting an almost nihilistic view of their lives and the world around them. Given these challenges the process of diagnosis may be more time consuming and complex. It is critical that therapists obtain parental input, particularly for those children and adolescents who are prone to denying and minimizing problems. Making a diagnosis of a Bipolar Disorder for a child or adolescent is even more challenging. First, as with depression, symptom presentation may differ with children and adolescents. Children and adolescents are less mature, and as a result are prone to more volatile behaviors and moods. In addition, they are also more likely to act out feelings of upset. Thus, it is important to not read more into normal mood shifts and emotional volatility. Second, differential diagnosis determining which disorder is present is complicated by the overlap between symptoms of Manic and Hypomanic episodes and ADHD Attention deficit hyperactivity disorder. Impulsive, reckless, and disruptive behavior, are symptoms of both disorders. In addition, children and teens with ADHD are thought to be more emotional, have been found to be at risk for defiant behavior, and are prone to repeating problematic behaviors see section on ADHD. Similarly, children and adolescents who are depressed may exhibit irritable and disruptive behavior. Third, there are no clearly established criteria for diagnosing Bipolar Disorder in children and adolescents. Given these concerns, caution and thoroughness are the watchwords in diagnosing Bipolar Disorder in children and adolescents. It is important to not over diagnose children and adolescents and to be as sure as possible that current symptoms do not reflect a difficult temperament, significant family problems or stresses, or another disorder, such as ADHD or depression. It is also important to recognize that the presence

of one or two symptoms does not not mean that one has a given disorder. Thus, to diagnosis a Bipolar Disorder in an adolescent or child we would assert that: While there is less research on the treatment of depression in children and adolescents than in adulthood particularly on the treatment of bipolar disorder there is evidence that the treatment approaches that work for adults also help children and adolescents. While there is not a substantial body of research studies have supported the use of Family therapy, Interpersonal therapy, and Cognitive Behavioral therapy with children and adolescents with depression ref. As with adults, there is evidence that the combination of therapy and medication is the most effective approach for treating depression in adolescents. Early results from the TADS Treatment for Adolescents and Depression Study , a multi-site federally funded study of the treatment of moderate to severe depression in adolescents, supports the use of a combined treatment approach. Preliminary findings, from over adolescents diagnosed with Major Depression found that the combination of psychotherapy Cognitive Behavioral therapy and medication Prozac to be the most effective treatment ref. Given the research findings available the most reasonable course of treatment appears to be a combined approach, using both medication and therapy. However, as concerns have been raised about medication treatment with adolescents see below the option of utilizing psychotherapy alone is also a reasonable alternative. The use of medication with depressive disorders is more controversial in children and adolescents. This controversy has increased with concerns that anti-depressants SSRIs may increase the risk of suicidal ideation in adolescents. In the Food and Drug Administration FDA , following a review of the research on the treatment of children and adolescents with antidepressant medication, issued a public warning that antidepressant medications may induce suicidal behavior in adolescents. However, about 4 percent of those taking SSRIs experienced suicidal ideation ref. Other studies have reported more mixed results. For example, a recent review of studies suggests that the benefits of antidepressant medication outweigh the risks of not providing medication treatment ref. Given these findings further study is clearly needed. From a practical point of view, these findings suggest that antidepressant medication, when used with children and adolescents, should be closely monitored. There is evidence supporting the idea that children and adolescents receiving antidepressant medication should be in therapy. Early findings from the TADS research project, noted above, suggest that the use of therapy, in this case CBT, in conjunction with medication, lowered the risk of suicidal thinking for adolescents. This suggests that adding therapy provides additional safeguards for those vulnerable to suicide, according to the researchers. In conclusion the available research suggests that the combination of therapy and medication appears to be the most effective and safest approach for the treatment of depression in children and adolescents. Why family involvement in treatment is critical Developmental issues with treatment. We cannot stress enough that children and adolescents are not miniature or youthful adults. Even the brightest adolescents do not have the emotional resources that they will have in adulthood. In addition, children and adolescents do not have the perspective that adults do. Children and adolescents have more difficulty projecting ahead, realizing that their lives and situations will change, i. As a result, they may be vulnerable to feeling more overwhelmed when depressed because they are not able to envision their lives changing. Similarly, children and adolescents are more impulsive than adults. This combination can be quite problematic. Specifically, depressed adolescents may believe that their lives will never change and be a risk for impulsive action suicide attempts, substance abuse, or other reckless behavior to try and manage or end their emotional pain. Treatment is also complicated by the fact that: Thus, children, and even adolescents, may have trouble describing their symptoms and talking about their feelings. Second, children and adolescents have less self control than adults, are not as disciplined. As a result, they may have more difficulties following treatment recommendations and be more prone to wanting quit therapy. Third, peer and social pressures may increase adolescent acting out and resistance to treatment. Finally, children and adolescents are affected by their families. Parental vulnerabilities, family stresses, and family conflicts all may exacerbate problems and hamper treatment, if not addressed. It is also important to note that because depression and mood disorders appear to run in families that depressed teens and children may have one or more depressed parent. Why family involvement is critical: Help defining their problems Assistance in following through with treatment

More structure, particularly if behavioral problems are present Resolution of family problems exacerbating depression In conclusion, we believe that parental involvement is a necessary component in the treatment of children and adolescents with depression or a mood disorder. A non-profit website founded and directed by parents. It offers solid information about bipolar disorder in children, as well as links to various resources. This site offers information on childhood and adolescent depression and mood disorders, along with links to multiple resources. The main drawback of this site is the frequent annoying pop up ads. One of the most well-respected works on bipolar disorder in children and adolescents. References for this article: Department of Health and Human Services. Child and Adolescent Bipolar Disorder: Bipolar disorders in a community sample of older adolescents: Journal of Affective Disorders, ; Geller B, Luby J. Child and adolescent bipolar disorder: The coming of age of couple therapy: Journal of Marital and Family Therapy, , 26, Long-term Effectiveness and Safety Outcomes. Archives of General Psychiatry. Oct ; VOL 64 Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Journal of the American Medical Association, Aug. Antidepressant Medications for Children and Adolescents: Information for Parents and Caregivers. National Institute of Mental Health, www. A Meta-analysis of Randomized Controlled Trials. Centers for Family Change.

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Left untreated, depression can be devastating for those who have it and their families. Fortunately, with early detection, diagnosis and a treatment plan consisting of medication, psychotherapy and healthy lifestyle choices, many people can and do get better.

Lack of interest in activities Hopelessness or guilty thoughts Changes in movement less activity or agitation Physical aches and pains Suicidal thoughts Causes Depression does not have a single cause. It can be triggered by a life crisis, physical illness or something elseâ€”but it can also occur spontaneously. Scientists believe several factors can contribute to depression: When people experience trauma at an early age, it can cause long-term changes in how their brains respond to fear and stress. These changes may lead to depression. Mood disorders, such as depression, tend to run in families. Marital status, relationship changes, financial standing and where a person lives influence whether a person develops depression. Imaging studies have shown that the frontal lobe of the brain becomes less active when a person is depressed. Depression is also associated with changes in how the pituitary gland and hypothalamus respond to hormone stimulation. People who have a history of sleep disturbances, medical illness, chronic pain, anxiety and attention-deficit hyperactivity disorder ADHD are more likely to develop depression. Some medical syndromes like hypothyroidism can mimic depressive disorder. Some medications can also cause symptoms of depression. Drug and alcohol abuse. This requires coordinated treatment for both conditions, as alcohol can worsen symptoms. Diagnosis To be diagnosed with depressive disorder, a person must have experienced a depressive episode lasting longer than two weeks. The symptoms of a depressive episode include: Loss of interest or loss of pleasure in all activities Change in appetite or weight Sleep disturbances Feeling agitated or feeling slowed down Fatigue Feelings of low self-worth, guilt or shortcomings Difficulty concentrating or making decisions Suicidal thoughts or intentions Treatments Although depressive disorder can be a devastating illness, it often responds to treatment. The key is to get a specific evaluation and treatment plan. Safety planning is important for individuals who have suicidal thoughts. After an assessment rules out medical and other possible causes, a patient-centered treatment plans can include any or a combination of the following: Medications including antidepressants, mood stabilizers and antipsychotic medications. Exercise can help with prevention and mild-to-moderate symptoms. These include electroconvulsive therapy ECT for depressive disorder with psychosis or repetitive transcranial magnetic stimulation rTMS for severe depression. Light therapy, which uses a light box to expose a person to full spectrum light in an effort to regulate the hormone melatonin. Alternative approaches including acupuncture, meditation, faith and nutrition can be part of a comprehensive treatment plan, but do not have strong scientific backing. Read more on our treatment page.

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Talk to trusted family members or friends to help them understand how you are feeling and that you are following your doctor's recommendations to treat your depression. In addition to your treatment, you could also join a support group.

Thought disorders not requiring hospitalization, such as paranoia and hallucinations Patients who need a more intensive, structured program than traditional outpatient visits can provide Patients who may not require hospitalization, but who may benefit from hands-on intensive day-long therapy without requiring an overnight stay Patients transitioning from hospitalization who need on-going, intensive care Learn more about partial hospitalization for adults here. PHP is a treatment option for adolescents age and is beneficial for parents and families seeking a therapeutic environment for their children struggling with mental health problems. The program operates Monday through Friday from 9: Doctors, nurses and therapists will work closely with families to design the right treatment plan for each patient. Who Benefits Patients whose conditions have not responded to other therapies Residential Program Patients of different ages have different needs. The Williams House is our adolescent comprehensive diagnostic assessment and treatment program. It focuses on intensive assessment and treatment readiness for patients age 11 through 17 who suffer with complex, co-morbid mental health issues. The Sibcy House is our comprehensive diagnostic assessment and treatment readiness program for adults. Often, patients arrive at Sibcy House with multiple diagnoses and a history of treatment attempts. Typically it can take up to 17 years before research findings become fully integrated into routine diagnostics and treatment. McElroy, MD â€" have created a research-driven, landmark program for the successful treatment of mood disorders. Their team of clinical researchers has brought six pharmaceuticals to the market. Collectively, the team has published more than research papers on the subject of mood disorders. They also work extensively with other leading research facilities around the country. Nationally and internationally regarded clinician-scientists at the Research Institute work in collaboration with top investigators at the University of Cincinnati College of Medicine and other leading academic research institutions around the country. Lindner Center of HOPE researchers have been instrumental in bringing six new drugs to market for depression and bipolar disorder for improved therapeutic efficacy and safety. Current Research Studies Research in genetics, brain imaging, psychopharmacology and psychotherapy evidence provides new methods and treatments for even the most treatment resistant mood disorders. The staff closely integrates research studies into proven, multidisciplinary programs to benefit patients and further treatment. Visit the Research Institute page for more information about current studies. Team Global Experts in Mood Disorders Lead Treatment Specialists at Lindner Center of HOPE are internationally recognized for their leading research, advanced training and proven results in identifying and treating basic and treatment resistant mood disorders.

Chapter 9 : Teen Depression: The Pros and Cons of Medication

Background. Adolescent depression is common and leads to distress and impairment for individuals/families. Treatment/prevention guidelines stress the need for good information and evidence-based psychosocial interventions.