Trauma Induced Adolescent Depression:
The Connection between Trauma and Depression

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Abstract

This report outlines adolescent depression and the therapeutic approaches that can be used to treatment that depression. At the start of the report the writer discusses the development of adolescent depression with a focus on trauma. Next the writer includes how adolescent depression presents and effects individuals with the disorder. After that section of the report, the writer included a case study of an individual with trauma induced depression and how it presents in this individuals life. Lastly, the writer included three different therapeutic approaches that have been proven to be successful in treating adolescent depression.

Key words: Depression, Post-Traumatic Stress Disorder, Cognitive-Behavioral Therapy

Introduction

During the years of adolescence a lot of change occurs biologically, physically, and mentally. Issues such as separating from parents, relationships with friends, and academic expectations can bring a lot of unexpected behaviors and mood swings for adolescents. However for some teens, the downs are more than just brief feeling of sadness and these adolescents may be presenting signs of major depressive disorder. Although depression can occur at any time in an individual's life, symptoms often present differently depending on the age of the individual, such as an adolescent with depression compared to an adult with depression (Mayo clinic, 2016).

"Adolescent major depressive disorder had an estimated point prevalence ranging from 3 to 5% and a cumulative lifetime rate approaching 20% by age 18" (Clark & DeBar, in Weisz and Kazdin, 2010, p. 110). Adolescent depression can be characterized by miserable or irritable mood, loss of interest in school and recreational activities, feelings of boredom, sleep and appetite changes, low self-esteem, and hopelessness. In addition, depressed teens have an increased risk of suicide, other psychiatric disorders, and substance abuse. The causes of adolescent depression include a combination of biological vulnerability and environmental stressors (Weisz & Kazdin, 2010, p. 140). In fact, 90% of suicide amongst teenagers had a diagnosable mental illness, depression being the most common (Elliott & Tyrrell, 2016).

Development of adolescent depression with a trauma focus

Adolescent depression can develop due to a countless amount of reasons, such as abuse, certain medications, stress, attachment problems, death, major life events, substance abuse, serious illness, or simply an individual's genetics or biological make-up. However, with that being said, it is important to understand that each form of depression and the development presents differently, making it a very complex disorder. In addition, to make adolescent depression even more complex, it is rarely the single diagnosable disorder that a child may be

presenting with. There are a number of disorders that frequently occur alongside adolescent depression and depressive disorders. The most common co-occurring, co-morbid conditions are: Post-Traumatic Stress Disorder, Anxiety disorders, Panic disorder, Obsessive-compulsive disorder (OCD), Alcoholism/Substance abuse (which can also be a cause or effect of depression as well), Eating disorders, and Borderline personality disorder (Beauchaine & Hinshaw, 2008).

Many times, adolescents that become depressed report a single traumatic event before becoming depressed. While trauma is a normal reaction to a horrifying event, the effect can be so severe that it can interfere with an individual's ability to live a normal life. During a traumatic event, an individual may feel emotionally, cognitively, and physically overwhelmed. Traumatic events commonly include both physical and mental abuse, helplessness, pain, confusion, and/or loss. Examples of trauma include but are not limited to rape, domestic violence, neglect (RAD), natural disasters, severe illness or injury, the death of a loved one, and/or witnessing an act of violence (Janoff-Bulman, 1985). After a traumatic event an individual often experiences emotional and/or physical symptoms of distress that commonly relate to depression and Post-Traumatic Stress Disorder.

It should be emphasized that trauma is a subjective experience; meaning that two different people can experience similar events and have completely different effects. However, according to The National Center for PTSD, "a survey of survivors from the Oklahoma City bombing showed that 23% had depression after the bombing. Also they stated, "results from a large national survey showed that depression is nearly 3 to 5 times more likely in those with PTSD than those without PTSD (National Center for PTSD, 2015). These statistics prove that there is a strong correlation between traumatic events and depressive disorders.

In addition to the statistics that prove the relationship between traumatic events and the development of depression, is the neurology behind the correlation. Exposure to traumatic events have been found to cause serious damage to an individual's health later in life. The hormones of adrenalin and cortisol released during stressful situations cleanse the areas of the brain involved in memory and response to stress. Although these hormones mobilize brain systems critical to survival in crisis, excessive distress can lead to long-term changes in the brain. Also, in the brain of an individual that has experienced a traumatic event; the memory of the traumatic event is "engraved" more deeply than positive memories (Everything Counselors and Supervisors Need to Know about Treating Trauma). Also according to Rick Nauert PhD, research proves that serotonin levels were substantially lower in the group of patients diagnosed with PTSD than in patients who did not have PTSD, and also far lower in the patients who had been exposed to trauma but did not have PTSD (Nauert, 2015). Furthermore, there are numerous studies that show lower levels of serotonin are directly correlated with depressive mood disorders.

Presentation of adolescent depression

Adolescents that struggle with depression present in many different ways. Depression can lead to multiple emotional and behavioral problems, both internal and external, that can hinder an individual's social interaction in a specific level, such as at home, in school, or at a place of employment. When children internalize their depressive emotions often times they will remain in solitary with little to no interaction with others, have a loss of interest or enjoyment in practically all activities, have a sense of worthlessness or guilt for no reason, and an overall sadness and hopelessness (Causes, Symptoms & Effects of Depression, 2016). Also, one of the most common internal adolescent depression presentations is internal emotional dysregulation, which often manifests with the children having difficulty calming down when upset, difficulty decreasing

negative emotions, being less able to calm themselves, and more. In addition, continual internalization of depressive emotions often leads to negative self-talk and self-blame (especially with trauma induced depression). Negative self-talk is the act of using words and phrases while thinking or talking to yourself that build irrational beliefs about yourself. For example, “how come I could not do that, I am a looser” or “I am nothing compared to those people” (Radwan, 2015). Self-blame is the act of blaming yourself for a situation that you could not control. Self-blame is very common with individuals that have experienced trauma. According to Janodd-Bulman, there are two different types of self-blame: behavioral self-blame and charaterological self-blame. Individuals that have behavioral self-blame believe that if they make changes, they will be safe. Charaterological self-blame is much more maladaptive and recovery can take years or even decades. An individual that has charaterological self-blame often thinks that they were chosen for this event and this often leads to even a further feeling of depression and/or helplessness (Janoff-Bulman, 1985). In addition, adolescents that are experiencing depression that was brought on by trauma may become avoidant of people or situations, experience flashbacks, or have vivid nightmares of the event.

On the other hand, adolescent depression can manifest in an external manner. When adolescent depression externalizes, often times it will present with a sense of fatigue, poor concentration, increase or decrease in appetite, increase or decrease in sleep, a feeling of emotional numbness, and irritability. Also, adolescent depression can create change within behavioral presentation such as efficiency completing tasks, psychomotor disturbances – agitation or slowed movement, and emotional dysregulation. External dysregulation usually presents with the children being impulsive, focusing on the negative, difficulty identifying emotional cues, and more. When an adolescent has trauma induced depression, that adolescent

may externally present with increased anxiety or increased panic attacks and be unable to cope in certain situations, especially situations that remind them of the traumatic event or events (Giller, 1999).

According to the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5) major depressive disorder is characterized as, "five (or more) of the following symptoms having been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure." The following nine symptoms are:

> (1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day. (3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (4) Insomnia or hypersomnia nearly every day. (5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down). (6) Fatigue or loss of energy nearly every day. (7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day. (8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others). (9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (American Psychiatric Association, 2013, p. 94)

In addition to having to manifest at least five of these symptoms for individuals to be diagnosed with major depressive disorder, the individual must not display these symptoms due to other medical reasons or due to physiological effects of a substance and the symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2013, p. 94-96).

Effects of adolescent depression with a trauma focus

The effects of adolescent depression are often confused with the symptoms of depression. Even though they may look very similar and "sometimes they are the same" they serve a much

different purpose. Effects of adolescent depression include but are not limited to low self-esteem, alcoholism and substance abuse, academic problems and failure, difficulties with family conflicts and other relationships, eating disorders, risky sexual activity, social isolation, self-harming behaviors, and suicide (Causes, Symptoms & Effects of Depression, 2016). Although these behaviors are often seen as "negatives" they are behaviors that adolescents use to regulate their emotions. Even though these adaptations may come at a cost, they regulate that person's emotions for a certain amount of time.

Case study of Adam

Basics

The client, Adam, is a fifteen year old white male. Adam currently resides in Chicopee with his mother Jane (45), father Bill (47), his younger sister Gabby (5), younger brother Seth (13), and his older half-sister Amanda (20). Adam is currently enrolled as a sophomore at Chicopee Comprehensive High School and is single. Adam is seen at River Valley Counseling Center through the School Based Program in an out-patient capacity. Services are voluntary and completed while in school. Sessions are comprised of Adam and the social worker however; the initial intake was completed with Adam's mother, Adam, and the social worker on-sight at River Valley Counseling Center in Chicopee. Adam has a multitude of environmental stressors that cause him to present with both major depressive disorder and post-traumatic stress disorder.

Client history

Adam constantly reports verbal and emotional abuse from his father, yet he has never expressed physical or sexual abuse. Adam also stated that he feels his father has been emotionally neglectful in the past, such as not being a positive role model or father figure and also not being reliable or dependable, all of which are important things that a child needs to be successful. Adam reports witnessing his father doing and dealing drugs in his presence, yet this has not

happened in years. This places a lot of pressure on Adam because he feels that it is his duty to be a father figure to his younger siblings because he is the oldest male sibling in the family.

Adam reported that the sudden death of his brother in 2013 is an extremely traumatic event for him. He stated that his brother died of an overdose of drugs and alcohol and he was present in the house during the finding of the body the next morning. Adam feels a great deal of guilt over not "being there" or doing something to otherwise change the situation with his brother. Even though he is constantly reassured by his mother and clinician that it is not his fault and he could not have changed things with his brother, he still feels guilty.

Prior to his current treatment at River Valley Counseling Center, Adam has no past treatment of mental health issues. However, Adam reports that he believes his depression started around the age of nine. In addition, Adam reported that he was seen at Baystate Hospital ED a few years ago for a panic attack.

Client family history

Adam reported that he was born and raised locally, and that due to marital discord his mother had wanted to move the family to North Carolina in 2013. However this did not happen because his older sister (20) wanted to be able to finish high school and had a boyfriend here. Adam stated that he has a younger brother (13) and a younger sister (6). Adam's father is reportedly in and out of medical facilities due to obesity and Adam "resents" him as a father. Prior to his death, Adam's brother struggled with substance abuse and mental health issues and was reportedly in and out of the home and the Adam's life because of these issues.

In addition, Adam and his mother reported family history of mental illness and substance abuse on both paternal and maternal sides, specifically depression and bipolar disorder. There is also a significant family history of diabetes. Adam's mother also stated that the client's maternal uncle was murdered at age 42 and maternal aunt died due to complications with asthma.

Furthermore she stated that while in inpatient psychiatric units, Adam's brother made threats to strangle other patients and also threatened to harm himself, and on one occasion did harm himself.

Client strengths

The client is highly intelligent and is willing to engage in services. The client gets good grades and is motivated to keep good grades. The client states that he is great with kids and animals, and is currently enrolled in a child development course at school. In addition, the client recently began wrestling for his school, and really enjoys being active. The client describes his living environment as a strength excluding his father. The client states that he has social support, and "understands how to get close to people without being awkward." Client reported that the neighborhood is safe. Throughout sessions the social worker is comfortable in stating that the client is friendly, engaging, caring, thoughtful, sociable, and well-spoken.

Adam's presentation in relation to trauma induced depression

Development of presentation

Unfortunately Adam has experienced multiple traumatic events that have lead to depressive symptoms. Adam's past history of abuse and death have lead Adam to experience emotional and/or psychical symptoms of distress.

Symptoms

Adam has many classic symptoms of adolescent depression such as no interaction with others, having a sense of worthlessness or guilt for no reason, and an overall sadness and hopelessness. However, Adam's presentation differs because he has shown an increased interest in activities during the last year; however this could be related to his desire to get "fit" so he does not "look like his father." Also Adam has a large amount of self-blame and negative self-talk. He has a huge amount of self-blame around the death of his brother and has negative self-talk around the

future. Negative self-talk examples may include, “nothing is going to change” or “nothing will bring my brother back.” Even though a majority of Adam’s symptoms manifest internally, Adam does have some external symptoms such as fatigue, poor concentration, decreased appetite, emotionally numbness, and irritability. At times, Adam easily becomes frustrated by his father which leads to anger management problems.

In addition to the depressive symptoms, Adam presents many symptoms of trauma. These symptoms include intrusive thoughts of his brother’s death, avoiding situations and places that remind him of his brother, fears that any memory of his brother will spark a negative flashback causing him to blackout, and constant vivid nightmares about his brother that cause him to wake up in the middle of the night screaming. In addition, Adam “resents” his father due to the past abuse and fears for his family when he is not home to “protect” them.

Client self-harm and suicide history

Around the time that his brother died in 2013, Adam reported self-harm behaviors, such as cutting and burning. These behaviors lasted for about a year. Adam also stated that a year ago he had suicidal ideations and he held a knife to himself but did not act any further.

Hallucinations

Due to the death of Adam’s half-brother, Adam and his mother stated he was hearing voices telling him to kill himself or others. At the end of the last school year, Adam’s school had major concerns regarding the auditory hallucinations telling him to kill, and that is why he began services at River Valley Counseling Center.

Focus on strengths and needs

Adam is highly intelligent and very motivated to change but tends to withdraw in times of sadness. Adam would benefit from a safe space to explore his thoughts around grief, loss, and trauma and develop appropriate coping skills for handling recurring symptoms. In addition,

Adam could benefit from Cognitive-Behavioral Therapy and exploring his thoughts, feelings, and behaviors.

Interventions

There are multiple different therapeutic approaches and theories that have been proven to be successful in treating depression in adolescents. These include but are not limited to Interpersonal Therapy, classic Cognitive-Behavioral Therapy, Rational Emotive Behavioral Therapy, Solution-Focused Therapy, and Activity Based Therapy.

Cognitive-behavioral therapy

According to Flynn and Warren, fewer than 20% of people seeking help for depression and anxiety disorders receive cognitive-behavioral therapy (CBT), even though it has been proven to be the most established evidence-based psychotherapeutic treatment for depression (Flynn & Warren, 2014). Although CBT is considered to be the most traditional psychotherapeutic treatment for depression, the social worker has to appropriately select the clients they implement CBT with. Clients that receive CBT and have the greatest success are often those that are intelligent and willing to change. Intelligence is a helpful trait because an important aspect of CBT is psycho-education and teaching the client that irrational thoughts, expectations, and perceptions exist. To use CBT effectively, the client first needs to have a strong understanding of the cognitive behavioral model and be able to relate that model to their own personal life.

CBT at its most basic form is based around how individuals think, how an individual feels, how an individual acts, and how each of these three ideas interact together. Simply, an individual's thoughts establish how an individual feels and behaves. The overall goal of CBT is to change patterns of thinking and behaving of the individual, which in turn will change the way the individual feels (McLeod, 2015).

In general, cognitive-behavioral therapy focuses on identifying problematic thoughts occurring in three forms, automatic thoughts, rules or intermediate beliefs, and core beliefs, that influence the negative behaviors or thoughts of an individual. First, *automatic thoughts* which are known as the most basic level of cognition are, "derived from the self, the world, other people, and/or the future arise spontaneously and are not consciously directed, and produce dysphoric affect when associated with psychological disturbance" (The Concepts of Cognitive Behavioral Therapy). An example of an automatic thought may be, "the pain is getting worse, so I must be getting worse." Next *rules or intermediate thoughts* are expected unspoken rules, assumptions, or expectations created by an individual. These rules, assumptions, or expectations created by an individual can be created for himself or herself or others. For example, "if I ignore my symptoms, my illness will go away" or "sick people are a burden." Lastly, *core beliefs or schemas* are beliefs individuals hold about themselves, the world around them, and others. They are subconscious and so deeply embedded within us they often go unrecognized but constantly affect our lives and the way we think (Taylor, 2006, p. 17-18).

Multiple times Adam has stated to the social worker that even though society states that children are supposed to respect their fathers, I do not have to do that because he does not show me respect or love. Adam's beliefs and perception of his father is that no matter what his father does, it is abusive and forceful. However, Adam's father may have the belief that Adam is a rebellious teen that does not what to do anything because he is lazy and a "typical" teen. In therapy it is highly important to break down these expectations and beliefs that Adam has about his father. With CBT it is important the social worker plays the role of the coach or expert and teach the client how their beliefs, perceptions, schemas, and expectations may be distorted due to past experiences.

Physical activity based therapy

Physical activity based therapy stems from the idea that adolescents that are experiencing depression often struggle to express their emotions and feelings, especially when sitting across the table from a "therapist." The hope is that physical activity such as lifting weights, playing basketball, playing soccer, skateboarding, and more will allow the adolescent to become comfortable and in turn open up and share their feelings and emotions. In addition, physical activity will allow the client to relieve stress and anger in a healthy and socially acceptable way. Within the study, Physical Activity Interventions and Depression in Children and Adolescents, it stated that "there was a small significant overall effect for PA on depression" (Brown, Pearson & Braithwaite, 2013). However, more studies and information needs to be collected to confidentially state that activity based therapy is effective in reducing depressive symptoms in adolescents.

As stated above, selecting this treatment model for the appropriate client is highly important to that client's success in treating their depression. For example, if the social worker selects an individual that dislikes physical activity then this treatment will most likely have a lower success rate compared to a client who enjoys physical activity. One major downfall of this treatment model is that a large amount of depressed adolescents do not want to engage in activity, however that is not the case for all depressed adolescents.

Adam has expressed to the social worker that he loves to be active and "wants to get fit." However, the "wanting to get fit" is based around his perception that being overweight makes him look like his father. Even though this irrational perception and thought is unhealthy, it is a beginning point to start with physical activity based therapy. Physical activity based therapy will also help Adam open up and communicate with the social worker in a more natural manner than in an office setting.

Interpersonal therapy

Interpersonal Psychotherapy (IPT) was initially created for non-psychotic, depressed adults. However, IPT has been modified to serve adolescents in addition to adults. Both IPT and Interpersonal Psychotherapy for depressed adolescents (IPT-A) have their roots in interpersonal theory and attachment theory. The structure of the IPT-A protocol includes three phrases: initial (weeks 1-4), middle (weeks 5-9), and termination (weeks 10-12). IPT-A is an outpatient treatment developed for clinically depressed adolescents ages 12-18, with limited inclusion of parents and lasts for 12 weeks with a total of 12-15 sessions. It can also be used with adolescents with comorbid presentations like anxiety disorders, PTSD, and oppositional defiant disorder (Weisz & Kazdin, 2010, p. 140-154).

During adolescence, interpersonal bonds are changing, and teens want more independence from parents and become more connected to peers. IPT-A addresses interpersonal issues such as: negotiating peer relationships and peer pressure, the development of initial romantic relationships, and parental separation and divorce. The theoretical basis of IPT and IPT-A is that clinical depression takes place within an interpersonal context (Weisz & Kazdin, 2010, p. 140-154)

According to IPT-A, there are three components of depression: symptom formation, social functioning, and personality. The therapist intervenes with only the first two components which are symptom formation and social functioning during session. IPT-A is a brief treatment which focuses on the present and assumes that improvement in one's mood can be achieved through interpersonal intervention. IPT-A aims to decrease depressive symptoms and improve interpersonal relationships through psycho-education, interpersonal skills building, and by creating a supportive therapeutic relationship that encourages the understanding and expression of affect. Success in treatment leads adolescents to a better understanding of their emotions, what

interpersonal situations lead to both positive and negative feelings, and how to communicate feelings to others. This is done by building skills that are directly linked to affect identification and takes place in session as therapist models appropriate interpersonal skills and gives feedback to adolescents regarding their style of communication (Weisz & Kazdin, 2010, p. 140-154).

Adam would greatly benefit from IPT-A because it focuses on interpersonal skills and affect identification, and also because it has been successful working with adolescents that experience depression and post traumatic stress disorder. Adam has a tough time understanding his feeling around his depression and communicating his feelings to others. With the aid of the therapist, Adam would gain knowledge around depression and the "what it is" through psycho-education and will learn skills around identifying and communicating his emotions. If Adam better understands his emotions, learns what interpersonal situations lead to both positive and negative feelings, and learns how to communicate those feelings to others, there is a good chance that he will overcome his depression.

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