



# PA CASSP

## Newsletter

**Pennsylvania Child and Adolescent Service System Program**

*A comprehensive system of care for children, adolescents and their families*

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## Childhood and Teen Depression: What You Need to Know

*by Christopher Petersen, M.D. and Santoshkumar Mathapati, M.D.*

### Is my child at risk?

In a startling revelation, a recent study showed only a third of teens with depression received mental health services and more than half received no treatment at all. The latest results comparing depression treatment in teens showed antidepressant use decreased, psychotherapy use decreased, and combination treatment also decreased. These decreasing trends in service utilization explain increasing suicide rates and suffering in our children. To minimize depression's future impact, more vigorous efforts are required to increase awareness in identifying mood and anxiety disorders and to improve access and availability of services.

### What is depression?

Depression is not merely the absence of happiness. Depression is a group of symptoms including sadness, depressed mood, loss of interest or pleasure, feelings of guilt and low self worth. Other symptoms may include disturbed sleep and appetite, decreased activity, low energy, poor concentration, wishing to be dead, suicidal ideation or attempts. Generally presentation of depression is the same in

children as in adults. However, there are some developmental considerations. Children present with less subdued symptoms, less delusions and fewer serious suicide attempts than adults. There are



different types of depression, such as Major Depressive Disorder (MDD) and Dysthymic Disorder (DD).

Children may present with mood instability, irritability, anxiety, and low frustration tolerance. Temper tantrums, physical/medical complaints and social withdrawal may predominate as they may not readily express their feelings. For example, Johnny is five years old. He gets cranky, looks worried and often complains

of stomach aches and headaches. He has frequent temper tantrums and it is getting difficult to soothe him. Another example is a 13-year-old named Bob. He used to play with his friends but now spends most of

his time alone and without interests. Things that were once fun now bring little joy and easily bore him. He is moody, irritable and easily frustrated. He has trouble sleeping and is losing weight. Teachers complain that Bob has been unfocused, does not complete assignments and has unexplained absences. Recently he told a friend that he feels no one cares about him, and he feels he is better

off being dead. He has even tried to run away from home. He is typical of a teen who is very depressed.

### Do children get depressed?

Yes, children do get depressed and the numbers are alarming! At any given point of time, 2 percent of children and 4-8 percent of adolescents have a MDD. The life time prevalence of depression in adolescents is estimated to be 20 percent.

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# Depression in Children and Adolescents

The Pennsylvania Youth Survey (PAYS) is administered every two years to public school students in sixth, eighth, 10th and 12th grades. Administered by the Pennsylvania Commission on Crime and Delinquency, the survey results "provide an important benchmark for alcohol, tobacco, and other drug use and delinquent behavior among young Pennsylvanians, and help indicate whether prevention and treatment programs are achieving their intended results." The survey also "assesses risk factors that are related to these behaviors and the protective factors that guard against them" (2009, p. 3).

Because studies have shown a link between the use of alcohol, tobacco and other drugs, the survey includes questions that determine whether the youth are exhibiting any symptoms of depression. The most recent Commission on Crime and Delinquency survey, administered in 2009, showed significant percentages of Pennsylvania students with symptoms of depression (<http://bit.ly/fQmfvU>):

- Nearly one third (31.6 percent) reported feeling "depressed or sad most days."
- 27.8 percent reported that "at times I think I am no good at all."
- 20.6 percent reported that "sometimes I think that life is not worth it."
- 13.7 percent reported that "I am inclined to think that I am a failure."
- Female students reported symptoms of depression at a much higher rate than males: for example, 38.7 percent of girls reported feeling sad or depressed most days, while 24.1 percent of boys reported the same symptom

A national study by the Centers for Disease Control and Prevention on "Youth Risk Behavior Surveillance—United States, 2009" reported the following (<http://1.usa.gov/anZoNU>):

- During the 12 months before the survey, 26.1 percent of students felt sad or

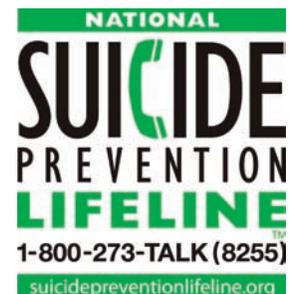
hopeless almost every day for two or more weeks in a row

- The rate was higher among African Americans and Hispanics than white
- 13.8 percent of students seriously considered attempting suicide, 10.9 percent made a plan, and 6.9 percent actually attempted suicide
- Pennsylvania-specific data indicated that 23.5 percent felt sad or hopeless; in Philadelphia, the rate was 33.8 percent. On this survey, Pennsylvania data on suicide attempts was similar to the national data.

The 2007 National Survey on Drug Use and Health showed that 8.2 percent of youths ages 12-17 experienced at least one major depressive episode in the previous year. Similar to the results of the other surveys, girls were far more likely to have had a major depressive episode than boys (11.9 percent versus 4.9 percent) (<http://1.usa.gov/g8UUPz>).

The forgoing information on the prevalence of depression in youth and its link to suicide is evidence that this edition's topic is important. If it is true that roughly one-fourth of all Pennsylvania youth are depressed much of the time, then it is imperative not only that we understand what depression looks like in children and adolescents but also that we promote the availability of effective treatments.

*Harriet S. Bicksler, editor*



*24-hour, toll-free suicide prevention service available to anyone in suicidal crisis. You will be routed to the closest possible crisis center in your area.*

# A Daily Learning Experience

by Leigh Carlson-Hernandez

In 2009, our 11-year-old son Evan was not his usual lively and positive personality. Normally, Evan would sit at the dining room table telling us of his daily adventures with wit and charm, but now after school he was retreating to his room to do his homework. Our smiling child was unexplainably sullen and tearful; he withdrew from his friends, lost interest in his favorite activities and talked frequently about being worthless and stupid. All of these were at odds with his normal personality. As the days passed, he retreated more from our busy family, became hostile, irritable and sad.

At the turn of the year, the school counselor informed us of the seriousness of Evan's changing mood. During lunch, he purposely cut his hands. He confided, "It makes me feel better when I am upset; I just have to do something to get it out of me." We immediately set up therapy. This did little to alleviate his symptoms; instead the intensity and frequency increased. By fall, Evan was in crisis; his behavior was unpredictable and his temper short. His final outcry was pulling out a kitchen knife and threatening his sisters. We were in shock and disbelief and didn't know where to turn, but then we called the local crisis network to help calm him down. They also gave us suggestions for what we should do next.

During the subsequent psychiatric evaluation, our suspicions were confirmed. Evan was coping with post-traumatic stress disorder, anxiety and depression. We suspected it evolved from his exposure to domestic violence and witnessing his biological father's complete suicide six years ago. Sitting with the psychiatrist we read the checklist of depressive symptoms: sadness, irritable or hostile mood which can include outbursts and shouting, loss of interest, feelings of worthlessness or inappropriate guilt, difficulty concentrating, recurrent thoughts of death or suicide and difficulty with relationships. Evan demonstrated nearly all of them. He quietly reported, "Some days I feel really crabby, like nothing, only dark-

ness inside. When I'm feeling like this, people cannot help me get out of it, so I confine myself to my room and keep to myself. Some days I am not happy and I am sad. I can't explain why I feel that way, I just do." The most frightening symptom Evan described was recurring thoughts of death. Our only comfort was that he was not thinking about how he would kill himself and was afraid of dying. We all had different responses to his depression diagnosis. I cried and felt an enormous sense of guilt and fear and my husband focused



on what we could do next. For Evan there was a sense of relief: "So... I am not going crazy. I am just depressed. That is the reason I feel this terrible." The psychiatrist felt we could return home because he was not a danger to himself or others. The only advice she could offer at discharge was that he needed continued therapy and possibly medication and we should ask him daily about his suicidal thoughts.

As parents, we felt deserted, helpless, useless and ineffective. Personally, I did not know if I possessed enough emotional strength to support Evan. We thought our experience getting mental health services for our younger daughter with early onset bipolar and anxiety disorder was good preparation for us as we forged ahead. We did not anticipate encountering such a high level of difficulty obtaining supports and services. Evan was already seeing a therapist who specialized in trauma; we wanted to continue and had difficulty finding a psychiatrist who

would treat Evan in collaboration with her. Many did not want to affiliate with a therapist they did not know personally. We spent over a month anxiously pleading and waiting for help.

Deciding to put your child on medication is tough and controversial. It was not a decision we took lightly. We discussed the options and fully involved Evan in the decision. Since my husband and I also have depression, we shared our own struggles and opinions about taking medication. These admissions showed Evan that depression is common and provided him with some comfort. His decision was, "If it will help me then I'll do it." After months of treatment, he reflects, "If I take the medication I feel good; if I don't, then I don't feel good that day."

In our home, depression is a daily learning experience. Each of us struggles in our own ways and we learn as we go, helping each other when we are down and understanding that our moods are not always what we wish they were. As parents, we continue to provide support, suggestions and love. We have learned when to push, when to pull, and when to back off and allow space. We are helping Evan recognize his moods and needs and learn how to advocate for his own mental wellness, so he may continue to thrive.

*Leigh Carlson-Hernandez works at the Alliance for Infants and Toddlers in Pittsburgh and is the family member co-chair of the Early Childhood Mental Health Advisory Committee.*

# Assisting Resistant Depression: A Summary of a Study of Adolescents

by David Brent, M.D.

When we first began treating adolescent depression two decades ago, we found that most of our teens responded to cognitive behavior therapy, an antidepressant, or the combination. Over the years, as the diagnosis and treatment of teen depression has become more commonplace, we noticed that our treatments did not seem to be working as well. Our caseload had shifted, and we were mainly seeing cases of teen depression that already had not responded to the usual treatments, which happens in about 40 percent of cases. To establish best practices for treating resistant depression, we developed the Treatment of SSRI-Resistant Depression in Adolescents study (TORDIA), which was a six-site study funded by the National Institute of Mental Health.

We defined depression as “treatment-resistant” when there was a lack of response after at the adolescent had been taking a selective serotonin reuptake inhibitor (SSRI) at an adequate dose for at least eight weeks. Our study was designed to answer the question, “After the first SSRI does not work, what next?” We randomized 334 teens with treatment-resistant depression to one of four treatments: switch to a new SSRI, switch to venlafaxine (Effexor-XR), switch to a new SSRI plus CBT, or switch to venlafaxine plus CBT. We chose to focus on treatment resistance to SSRIs because that class of medications is the single most common treatment for depressed teens in the community. Venlafaxine, a selective serotonin and norepinephrine re-uptake inhibitor, was chosen because, at the time, it was thought to be a particularly good treatment for resistant depression.

We found that the addition of cogni-

tive behavior therapy increased the response rate by about 15 percent, but that a switch to another SSRI was no different than a switch to venlafaxine. Cognitive behavior therapy was particularly helpful in teens with comorbid diagnoses, but was not helpful if the child had a history of abuse. Venlafaxine was associated with more side effects and suicidal ideation. By a year’s time, around 60 percent of the participants had achieved a complete remission.



Some important ingredients in recovery included being adherent to medication treatment, having an adequate blood level of the medication, getting at least nine sessions of cognitive behavior therapy, abstaining from drug and alcohol use (even below that of a formal mental health diagnosis), and addressing family conflict. Some participants did not respond to any of the treatments, but if they received another switch between 6-8 weeks into treatment, they were more likely to eventually respond than if the change in treatment was delayed.

For the depressed teen who has not responded to an SSRI, we now recommend switching to another SSRI with the addition of cognitive behavior therapy. Response rates are likely to be boosted further, and suicidal events less likely to occur, if patients get an adequate dose of

cognitive behavior therapy and medication, are adherent with their medication, abstain from alcohol and drug use, and family conflict is addressed. If a patient is not responding to a particular treatment regimen, we recommend making a change within 6-8 weeks. Our future work will concentrate on trying to figure out how to match psychotherapy and pharmacotherapy based on the profile of the adolescent, and how to help teens get better not only more often, but more quickly. In the meantime, clinicians should be both hopeful and persistent in treating youth with resistant depression, because over time, in our experience, there is an approach that is likely to help almost every patient.

*David Brent, M.D. is Professor of Psychiatry, Pediatrics, and Epidemiology, UPMC Endowed Chair, and Suicide Studies Directorat Services for Teens at Risk (STAR-Center) at the University of Pittsburgh.*

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# Adolescent Depression and Medication

by Ann Litzelman, M.A.

Mild to moderate adolescent depression is often treated with psychotherapy, sometimes called “talk” therapy. When depression is more severe, medication is often used as an additional intervention. The most common anti-depressants now being used are a group of medications called “selective serotonin reuptake inhibitors” (SSRIs), and a common SSRI for adolescents is Prozac. Questions about the effectiveness of medication to treat adolescent depression and possible side effects, including increased suicidality, have prompted a number of studies over the past several years.

The Treatment for Adolescents with Depression Study was funded by the National Institute of Mental Health and included 439 participants ages 12-17. These adolescents were randomly divided into four groups: those receiving only Prozac, those receiving a placebo and clinical management, those receiving cognitive behavioral therapy (talk therapy), and those receiving a combination of Prozac and cognitive behavior therapy. The initial results were published in 2004 and showed that after 12 weeks the combination treatment group had an improvement rate of 71 percent, the Prozac group 61 percent, the cognitive behavior therapy group 44 percent and the placebo group 35 percent. By 36 weeks, the combined group had 86 percent improvement while both the Prozac and cognitive behavior therapy group had 81 percent improvement (statistically the same rate of improvement as the combined group).

Overall this suggests that the combined group improved the most quickly, reinforcing the common view that combined treatment is most effective for moderate to severe depression in teens. Professionals interpret the combination

effect as the medication treating physical symptoms and then improvement in the physical symptoms allowing talk therapy to help the adolescent build skills and supports to deal with negative emotions and events.

After a year, most of the participants had maintained their improvement, and the full remission rate even improved. However about 30 percent of those who had been at remission at 36 weeks became depressed again during the following year. This reinforced the belief that

treatment works but also suggested that adolescents who have had major depression need to be monitored for a longer period of time.

Analysis of studies involving 4400 youth suggested that a small group of adolescents demonstrated increased suicidal thinking and behavior, often shortly after beginning a trial of antidepressant medication. In response, in 2004 the Federal Drug Administration added a black box warning

on all antidepressant medications used with children and adolescents. None of these youth actually committed suicide, but the review found that 2 percent of the youth who received a placebo had suicidality while 4 percent who received a medication had suicidality. In 2007 the warning was expanded to include young adults up to age 24.

The FDA warning does not state that antidepressants should be discontinued for all adolescents or that death is an imminent risk. Rather, the warning was intended to encourage an informed dialogue about risks and benefits, as there should be with any medication, and to warn that youth should be carefully monitored in case their condition worsens. Parents and caregivers should observe their teenagers closely and contact their physician if there are unusual changes in be-

havior (such as restlessness, agitation, irritability) or suicidality.

In light of the FDA’s black box warning and the concern that it could be misunderstood and fear could prevent individuals from considering medication that could be beneficial, further analysis of the study data to identify risk factors for suicidal events during antidepressant treatment was published in 2009. While about ten percent of all participants experienced some serious suicidal thinking or behavior during the study, the analysis found that these events were not confined to immediately following the start of medication. Furthermore, those who had already demonstrated suicidality before the study were more likely to continue to have it during treatment and there were additional interpersonal stressors in 73 percent of those cases. The teens in the study did not typically show increased irritability or agitation before the suicidality that occurred during the study. Therefore, this analysis recommended that youth be monitored for a longer period and that more research be done to determine if these findings apply to youth beyond the TADS sample and if there are different predictors for youth who did not have a history of suicidality.

In 2007, the American Academy of Child and Adolescent Psychiatry reviewed the effects of the 2004 black box warning, noting their original concern that the warning would do more harm than good. The Academy referenced several additional studies that showed either a smaller increase in suicide ideation or no difference, and noted that the youth suicide rate actually increased in 2004. The information suggests the need for ongoing attention to determining the most effective treatment for children and adolescents who are depressed.

*Ann Litzelman, M.A. is a licensed psychologist and consultant with Bureau of Children’s Behavioral Health Services, Office of Mental Health and Substance Abuse Services.*

*(see page 8 for references)*



# Depression in Infants and Toddlers: Fact or Fiction...and What to Do About It

by John Biever, M.D.

The topic of depression in infants and toddlers reminds me of Justice Potter Stewart's famous response in the matter of hard core pornography. He remarked that while what constitutes pornography might be hard to define, "I know it when I see it." Within the ranks of child psychiatric researchers, there is no consensus presently as to how to define depression in very young children. But in reading the existing literature on the topic, one is thoroughly impressed that these experts nevertheless "know it when they see it!" Therefore, while we wait for an official set of diagnostic criteria like we have for depression in adults and older children, we can nevertheless meaningfully talk about depression in very young children.

ZERO TO THREE, the distinguished group of early childhood mental health professionals, have suggested some characteristics of depression in infancy and early childhood in their diagnostic manual D-C: 0-3R:

- Irritable mood
- Diminished interest or pleasure in developmentally appropriate activities
- Diminished capacity to protest
- Excessive whining
- Diminished repertoire of social interactions and initiative

While these characteristics require research validation, they represent what skilled early childhood mental health professionals are looking at in a little child when they "know that they are seeing depression."

So why is it so difficult to form a consensus as to what depression looks like in an infant or toddler? Until the 1960s, mental health professionals generally believed that depression did not exist in children younger than adolescence. By now we have formal diagnostic criteria for school-aged children and proven treatment strategies. But this wariness of making new diagnoses persists for younger

children, and understandably so, for at least the following reasons:

1. Mood normally varies much more in preschool-aged children than in older persons, making it more difficult (and potentially hazardous) to discriminate a normal "down" state from depression.
2. We know that the mood state of very young children is far more dependent on the mood state of their caregivers than is that of older persons. Therefore, should we be diagnosing the relationship rather than the child?
3. Is the child's "depression" in fact adaptive in an inordinately stressful environment, such that diagnosing the child would draw attention away from the necessary focus of intervention?
4. Is the child's "depression" self-limited, so that in time it will spontaneously resolve with no treatment and with no long-term adverse effects?

I agree with those of my colleagues who give the benefit of the doubt to the notion that depression in infants and toddlers does exist, and occurs frequently enough that we must learn to understand it and be prepared to address it. What we do know in infant mental health is that several other mental illnesses not only occur at a substantial rate in infants, toddlers and preschoolers, but tend to darken the prognosis of the affected child for the rest of their lives. We also know that depression in school-aged children and adolescents tends to be relapse if left untreated. Therefore, detecting depression in very young children and intervening effectively, we are likely to reap substantial benefits not only for the child but for her parents, family, school, and community for many years thereafter.

What would these interventions look like? From what we already know, they would most likely include the following:

- Routine monitoring of the emotional health of the mother-infant pair, with special attention to mother's mood state. Depressed mothers are likely to have depressed infants, as babies do indeed get to know themselves as good or bad, desirable or undesirable, from the actions of their mother.
- Attention to the inborn temperament of children: What are the features of the infant or toddler that might make it more difficult for competent parents to relate in a predominantly joyful, positive manner? Parents can get great relief from an empathic explanation of temperamental differences between them and their children.
- Attention to the competency of the attachment bond between the infant/toddler and his or her caregiver(s). The good news here is that infants can develop more than one meaningful attachment, so that if one is insecure, another may be secure. Security of attachment has been shown to predict better mental health throughout later childhood.

So let us not wait for infant and early childhood depression to show up in the official diagnostic manual. Instead, in the spirit of Justice Stewart, let us take seriously the symptoms described above and provide interventions that are likely to be very helpful regardless of how we define the problem.

*John Biever, M.D. is a child psychiatrist consultant to the Office of Mental Health and Substance Abuse Services and is also in private practice in Annville.*

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Eleven-year-old children in the U. S. had the highest level of depression symptoms compared with those of 28 other developed nations. More than 30 percent of children expressed “feeling low” and number goes higher for adolescents. The incidence increases as children grow older, especially after puberty and more so in females. The children in this generation are spending increasing amounts of time being alone in front of media and have much “screen time.” Solitary and friendless children are at increased risk of depression.

An episode of depression can last for one or two months or can go on for years if untreated. Recurrence is very common; 70 percent in five years. In addition, 20-40 percent will develop bipolar disorder.

Many children with MDD/DD have an anxiety disorder, disruptive disorder, ADHD, or substance abuse disorder. These children and adolescents are also at a higher risk of legal problems, drug addiction, physical illness, early pregnancy, or poor work and academic functioning.

### What are the risks for suicide?

Alarmingly, suicide is the third leading cause of death in this population. Approximately 60 percent of those who have MDD report having suicide thoughts and 30 percent attempt suicide. In 2007, 14.5 percent of 9th and 10th graders in US reported suicidal ideation and 6.9 percent reported at least one suicide attempt in past year, yet often tell no one. Firearms, hanging and suffocation, followed by self-poisoning are the leading methods used in completed suicide. A psychiatric disorder is present in up to 80-90 percent of suicides.

### What are other risk factors for depression?

### Depression?

Depression is caused by interaction of genetic and environmental factors. The single most predictive factor is family history of depression. The presence of other psychiatric disorders, medical illness, and bio-psycho-socio-cultural factors contribute to depression. Serotonin (a neurotransmitter or brain messenger) is linked to an individual's ability to rebound from serious trauma or distress. A decreased level is associated with depression and suicide.

### How do you treat depression?

Depression is a very treatable illness. Treatment includes education, psychotherapy, and sometimes medication. Educating family members about causes, symptoms, and risks/benefits of various treatments is important. Supporting patients and partnering with family members and others in treatment is essential. Depression is an illness, not a weakness. It is no one's fault. One should not see behavioral problems as being bad or manipulative. Education is used to encourage participation in treatment, teach problem solving, learn coping skills, and instill hope. Family intervention is needed to improve the relationship between the caregiver and child. Confidentiality of the child or teen should always be respected in treatment. Students with depression may qualify for the Emotional Support program in school, including counseling and special accommodation in learning. These strategies are often sufficient in milder forms of depression.

If the symptoms are severe and impairing then psychotherapy and/or medication should be considered. Most cases of moderate depression are treated using Cognitive Behavioral Therapy (CBT) or In-

terpersonal Therapy (IPT). CBT and IPT have been shown to be beneficial in several studies involving youth. Strategies to treat severe depression should consider medication or a combination of medication and psychotherapy.

### What is the first step in getting help?

Once you suspect that your child is depressed, you should know where and how to get help. Your primary care physician or school guidance counselor can help find a qualified mental health professional. Ask them for a referral for assessment and treatment. Be involved in the treatment by regularly following up and attending appointments. Every teen and child deserves help, but needs your support in obtaining it.

### Resources:

- Pennsylvania Psychiatric Institute: [www.papsychinst.org](http://www.papsychinst.org)
- American Academy of Child and Adolescent Psychiatry: [www.aacap.org](http://www.aacap.org)
- NIMH: [www.nimh.nih.gov](http://www.nimh.nih.gov)
- WHO: [www.who.int/en/](http://www.who.int/en/)
- Crisis Intervention: <http://suicidehotlines.com/> and 1-800-273-TALK

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## I Took Control of My Life

by Alex Knapp

My life had finally turned around. Less than a year before, I had been successfully discharged from a residential treatment facility where I had been for more than a year. I was finishing my first semester of college. My grades were average, I had friends, and I didn't feel as though I was failing. Winter break ended and I returned to college hopeful, but inside I was dying.

I had a good scholarship at Keystone College and loved being 120 miles away from home. Returning to school this time was different; I didn't have the drive and I wasn't motivated. Three weeks into the semester my mental health spiraled out of control. I rarely attended class and I was using all my time and money to further my own addictions. I found myself angry and crying uncontrollably. I called my mother and said, "I can't do this." She tried to listen. My mother has always been one of the most supportive people in my life, but her words unintentionally dragged me farther into a slump. I felt like I was failing her, failing everyone.

I managed to convince her I was okay, but hung up the phone with every inten-

tion of ending my life, right there and then, but I couldn't. My friends found me and took me out to drown my emotions in alcohol.

At my mother's request, the following afternoon I went to the Student Counseling Center. A counselor confirmed what I already knew but was scared to admit: I was suffering from depression. I argued with the counselor. I wasn't always sad, I told her, explaining that when I was with my friends I was happy. I decided it wasn't a good idea to tell her that we went out every night to get high or drunk. She bought my line that we just hung out.

I stopped going to classes. I stopped showering. I ate maybe twice a week. No one seemed to notice, except for one professor who thought something was wrong but never pursued it. I failed all my classes, lost my scholarship and went home.

I was stuck in a hole so deep, I could no longer see the light at the top, but eventually I crawled up. Slowly life got better, but as the rollercoaster of my life went up the hill, it always came back

down. It took one more semester of failing college before I accepted I had a mental illness – I had depression.

In September 2010, I stood drunk in my apartment violently screaming at friends and family. At 2:00 a.m. I called my mother and through tears mumbled, "I don't want to be crazy anymore." She came and got me.

That night I took control of my life. I am a person living with a mental illness. I have survived depression. I am forging ahead on my road to recovery and not letting this disease determine my destiny.

*Alex Knapp is a 21 year old transition-age youth advocate for the Office of Mental Health and Substance Abuse Services (OMHSAS) Advisory Committee. He is an intake coordinator for the Disability Rights Network of PA and a member of the Pennsylvania System of Care Partnership Leadership Team. Alex encourages youth to share their experiences and opinions to promote system change. To learn more about the OMHSAS Transition-age Youth Subcommittee and how to get involved check out <http://bit.ly/g7d7pS>.*

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