TEXAS BEHAVIORAL HEALTH INSTITUTE

PRESENTS

A WORKSHOP ON

THE COMORBIDITY OF DEPRESSION, PTSD, AND SUBSTANCE ABUSE IN ADOLESCENT GIRLS

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PRESENTER

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INTRODUCTION

More and more clinicians, therapists, substance abuse counselors, mental health workers, and criminal justice workers are encountering and working with adolescent girls who present with co-morbid disorders, along with their substance abuse disorders. There are several issues that need to be considered and addressed to ensure that adolescent girls with co-morbid disorders will increase their ability to be successful adolescent girls and successful adults as well.
DEPRESSION, PTSD, SUBSTANCE ABUSE

POINTS TO PONDER

The etiology of substance abuse varies by gender and ethnicity, and there is a growing recognition that the meaning of substance use in adolescents may also vary. Teenage girls more readily talk out their feelings and experiences with others. This tendency is a strength that allows for the possibility of helpful feedback or support from others. This interacting quality has recently been related to reasons for initiating substance use among some girls (Donovan, 1996). For example, whereas boys tend to use alcohol for recreation and the known effect of the drug, girls have been found to use alcohol as a means of connecting to others. When faced with a drug-using group, some girls may use substances in order to not make the others feel uncomfortable by their lack of participation.

Depression and PTSD have been identified as factors strongly associated with substance abuse by adolescent girls. If drug use is understood as a mechanism to cope with emotional pain and trauma, it is not difficult to comprehend this connection. Several studies have supported the prevalence of significant co-morbidity of PTSD with other psychiatric disorders. Depression is one of the most common co-morbidities that accompany PTSD and substance use for adolescent girls (Yule, 1992; Yule & Canterbury, 1994).
DEMOGRAPHIC DIFFERENCES

Although depression can be found among children of all ages, it is more prevalent among adolescents. Rates of depressed mood tend to increase during early adolescence (ages 13 to 15), peaking at ages 17 or 18, before declining to adult levels (Petersen, et al., 1993). Although rates of major depressive disorder are equal for boys and girls during childhood, gender differences emerge during adolescence with rates among girls becoming double that of boys, similar to the female-male ratio found in adults (Noken-Hoeksema, Gingus, 1994).

CO-MORBIDITY

Many adolescent girls who present for treatment meet criteria for two or more diagnoses, a phenomenon referred to as co-morbidity. In principle, an adolescent girl could meet criteria for any two or more disorders; in practice, some combinations of disorders are much more likely to occur in girls than in others. Disorders that often go together are substance dependence and depression; PTSD, and substance dependence; substance dependence and anxiety disorders; and autism and mental retardation. Why some combinations of disorders are more likely than others, whether there are common features or simply definitional overlap and ambiguities of various disorders, and how co-morbidity disorders emerge are just some of the questions research raises about girls with co-morbidity. Co-morbidity is significant in providing treatment. Many adolescent girls may suffer significant impairment in multiple domains and areas of functioning (Kazdin, 2000). It is important in determining co-morbidity in adolescent girls to formulate a differential diagnosis, that is, simply, finding out what is going on with her. This is accomplished by 1) looking at presenting symptoms; 2) looking at her history (some clinicians make the mistake of looking only at present symptoms); 3) looking at stressors in her life that exacerbate symptoms, i.e., family, environmental, developmental. Co-morbidity, as it relates to substance abuse, PTSD, and depression, has been found to be closely associated with, or connected to, highly traumatic and destructive events for adolescent girls, i.e., physical or sexual abuse or the witnessing of violent acts. In these cases, girls might also present with traumatic stress (Bell & Jenkins, 1991). Interestingly, some child and adolescent experts found the severity of depressive symptoms related to the severity of PTSD symptoms, even after the degree of trauma and loss were measured. This finding suggests to some that depressive symptoms might develop as a result of PTSD symptoms and not simply in response to losses (Goenjian, et al., 1995).

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RISK FACTORS FOR PTSD

Exposure to high levels of trauma, such as threat of loss of life, threat of invasion of bodily integrity, i.e., sexual or physical abuse victimization, witnessing violent acts (rendering her co-victim), witnessing deaths, or losing a friend or relative, has also been identified as a significant risk factor for PTSD in adolescent girls. Girls and young children tend to report more PTSD symptoms (Garrison, et al., 1995). Some suggest that older girls may be more vulnerable to PTSD symptoms than younger girls. Ethnicity has emerged recently as a significant predictor of PTSD in children following acute events (Lonigan, et al., 1991). Among the victims of Hurricane Andrew, African-American and Hispanic children were significantly more likely to show PTSD symptomatology three, seven, and ten months later (LaGreca, et al., 1996). Limited financial resources for disaster recovery might have increased their risk. The availability of social support for adolescent girls is important, along with other sources of support, including peers, teachers, religious institutions. Adolescent girls who suffer with PTSD often resemble adults with this disorder. In fact, a not uncommon response to trauma in adolescence is the precipitator of precocious entrance into adulthood. The traumatized adolescent girl frequently becomes disenchanted and rebellious. The combination of poor impulse control, bad judgment, and reenactment behavior can be life-threatening. Suicidal behavior and drug abuse are common, as are truancy, sexual indiscretion, and delinquency. Adolescent girls are very sensitive to the implications and stigmatization of experiencing severe trauma and chronic problems in interpersonal relationships are frequent (Eth, et al., 1985). In addition, PTSD young girls who are traumatized chronically can develop symptoms that eventually meet the criteria for other AXIS I disorders (e.g., ADHD or depression and AXIS II disorders, including borderline personality disorder (Kazdin, 2000).

ETIOLOGY OF DEPRESSION IN ADOLESCENT GIRLS

Models to account for behavioral have been positive in most areas of psychological functioning, psychopathology, and psychobiological development. Depression in adolescent girls is no exception. Research indicates several risk factors for depression for adolescent girls (Kazdin (1989) and Weller and Weller (1990).

Risk factors for depression in adolescent girls can emanate from multiple sources, including loss of the primary object or parent through death or
abandonment and thusly, anger turned inward, which, from this psychodynamic
perspective, defines depression. This loss produces unsatisfied affection needs
and diminished self-esteem. Cognitively, you have depression in adolescent girls

as a result of cognitive distortions. Seligman (1975) introduced the concept of
learned helplessness, which basically posits the belief that “I do not have any
control over my situation, and there is nothing I can do about it, so I surrender,
acquiesce, because I can’t do anything about the situation.” This can or often
produces depression. Learned helplessness definitely has implications for
domestic violence prevention. Learned self-helpfulness vs. learned helplessness
are both cognitive constructs that can be learned and unlearned. Cognitive
distortions can affect an adolescent’s judgment about the social environment and
the world, for example, “I must be thin in order to be successful,” or “If I am not in
a relationship with a boy, then I must be inadequate.” In the cognitive approach
to depression, there are three types of negative thinking, according to Beck
(1979)—negative views of the self, of the world, and of the future. These views
can eventuate/produce depression in adolescent girls. The whole point of learned
helplessness is “I give in and I am helpless.” Behavioral formulations of
depression are based on the notion that depressive symptoms are learned
through interactions with the environment.

Social skills deficits, as well as other skill deficiencies, may be a function
of reinforcement histories. In other words, an adolescent girl, according to the
behavioral theory, may become depressed because of lack of environmental
reinforcement, and depressive symptoms in adolescent girls may also occur
because of a lack of reinforcers in the environment. An example of depression
caused by behavior reinforcement is, “If I drink with the other girls, I’ll be more
acceptable to boys, because all the girls I know drink and also have boyfriends,
so I drink, and I now have a boyfriend.” An example of depression as a result of
poor or lack of reinforcement is, “I go out of my way to please everyone, and
people still do not like me.”

LIFE STRESSORS/SOCIAL ENVIRONMENT

A lot of research demonstrates that stressful life events are more frequently
reported by depressed adolescent girls and the occurrence and number of
stressors appear to be positively related to depression in children. It is crucial for
those working with adolescent girls to understand the nature, importance, and
implications of this point and to see how the role of abuse and violence and other
gender-specific losses have not been addressed, i.e., physical or sexual abuse or witnessing the abusive acts which makes the girl co-victim. The stress over losses may also cause depression—losses such as:

- Loss of self-esteem, self-worth
- Loss of educational and vocational opportunities
- Loss of health
- Loss of childhood
- Loss of control over their bodies
- Loss of home and sense of permanence
- Loss of belief, trust, faith, hope
- Loss of credibility once labeled

It is apparent multiple losses or one that is salient or acute can very often eventuate into depression.

**GENETICS**

Research has demonstrated that there genetic influences on the occurrence of depressive disorders. Strober (1989) and Strober and Carlson (1982) were able to demonstrate that the cases of depressed adolescents and 35% of parents and 20% of second-degree relatives were depressed. An even larger percentage were depressed when adolescents were bipolar by diagnosis.

**SAFETY FOR GIRLS**

Pipher and others (Herman, 1981, 1992; Forman and Buck, 1988; Girls, Inc. 1996) content that the lack of viable options for girls to express their true selves leads them to act in ways that appear self-destructive but are often logical, adaptive responses to the world in which they live. Their behavioral actions and symptoms, reconditioned in this way, can be understood as acts of resistance and strength against a society that ignores and frequently damages them. Running away, truancy, suicidal gestures, depression, excessive dieting, weight gain, prostitution, early pregnancy, drug and alcohol use may all be signs that a girl is trying to protect herself from the onslaught of messages she receives on a daily basis, that she is bad, wrong, manipulative, frigid, unlovable, and weak. Lack of safety is definitely a cause for depression, anxiety, PTSD, and traumatic stress.

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ASSESSMENT FOR ADOLESCENT GIRLS WITH SUBSTANCE ABUSE AND PTSD AND DEPRESSION

Adolescent girls who abuse substances are prone to other emotional and behavioral problems, such as PTSD and depression (Newcomb, 1995; Winters, 1999A). The major challenge facing therapists is differentiating problems related to substance use from issues that are not drug-related. For instance, substance symptoms such as depression, serious familial conflict, and chronic school truancy are also common mental health issues for adolescents.

Adolescent substance abuse is best viewed on a continuum of drug use progression (Newcomb, 1995). Differentiating drug experimentation from substance abuse is a critical issue in conducting assessments with adolescent girls. Assessments for co-morbidity, i.e., substance abuse with PTSD and depression) should rule out other disorders or include features of other disorders (Chatlos, 1994). Feelings of depression, anxiety, and peer rejection have been found to be general predictors of drug disorders among adolescent girls. Special attention should be given to suicidality. This is especially important when assessing marijuana users, as their rate of suicidal ideation is three times as high as that of non-users (Greenblatt, 1979). For purposes of establishing treatment intervention, it is important to examine the motivation for adolescent substance use. Motivation includes 1) a peer motive—wanting to be accepted or dealing with rejection; 2) a coping motive—addressing feelings of anger, anxiety, fear, depression about school or home life, or lack of safety or predictability; 3) a drug experience motive—a desire to know the experience of the drug, often prompted by peer use. It may benefit the diagnosis/treatment plan to inquire directly what purpose or purposes her drug use serves.

GENDER RESPONSIVE TREATMENT

Treatment for adolescent girls with co-occurring disorders, i.e. substance abuse, PTSD, and depression, requires gender-responsive treatment, that is, treatment that responds to specific needs of girls. Laura Prescott, in her exemplary work, Adolescent Girls with Co-occurring disorders (1998), provides the following evidenced-based components for adolescent girls with co-occurring disorders.

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Create Gender-specific Programs and Practices Based on Normative Female Development

Using strength-based approaches rather than deficit-based models in all substance abuse and mental health practices serving adolescent girls in contact with the justice system acknowledges, reinforces, and supports their abilities. Focusing on the skills adolescent girls have cultivated in order to survive re-frames their behavior as normative, adaptive responses, increases self-esteem and further obviates the negative effects of labeling. There is a need for model programs that are supported by policies valuing female experiences, building on relationship models known to be effective with adolescent girls, and addressing all of the interrelated needs of these young women.

Design Strength-based Assessments That Determine Levels of Distress for Adolescent Females

Innovative assessments have been designed by programs in collaboration with court personnel and community service agencies concerned with the mental health and substance abuse needs of adolescent girls in contact with juvenile systems. These assessments could be the basis for developing strength-based model assessment forms that are gender-specific, and culturally and developmentally sensitive.

Provide Small, Single-sex Dialogue Groups for Adolescent Girls

Adolescent girls, particularly those with multiple vulnerabilities, are often reluctant to seek assistance or have relatively little access to mental health and substance abuse information and treatment. Small, single-sex therapy groups have been successfully used to facilitate discussions pertaining to female health care, physical and sexual abuse, school performance, depression, and substance abuse. The dialogue within groups provides a safe way for girls to explore issues of immediate concern, develop trust, and minimize shame. Those working with adolescent girls relate the severity of damaged self-esteem and resulting isolation seen in these young women, particularly those with emotional, mental health, and substance abuse concerns. Young women engaging in high-risk behaviors frequently do not have anyone to approach for assistance and frequently become withdrawn, depressed, and self-injurious. Small group interaction and relationship approaches have been useful in modeling positive female relationships and facilitating the development of peer support systems for girls in the community and in juvenile detention settings.
Adapt Trauma-based Treatment Models

Trauma-based treatment models known to be successful with adolescent girls with co-occurring disorders in residential and detention centers need to be adapted for female adolescent girls in similar settings. Trauma-based models can be patterned after models utilized for women in therapeutic community settings and half-way houses.

Increase Alternative, Single-sex, Residential Placements in Community

In order to prevent recidivism and decrease retraumatization, integrated services are most successful when combined with creative residential options in the community. To successfully achieve this, strategies are required to ensure that the allocation of state-level funding is directed toward alternative single-sex, residential construction in the community. Increasing the availability of single-sex community alternatives specifically for female juveniles with co-occurring disorders are needed in addition to the following:

- foster-care placements.
- alternatives for adolescents running from abusive homes.
- a network of “safe homes” for temporary placement.
- alternative drop-in sites located centrally in communities.

What About Girls in the Juvenile Justice System with Co-occurring Disorders?

Louis J. Kraus, M.D., recently reported in the American Academy of Child and Adolescent Psychiatry Task Force on Juvenile Justice Reform, October 2001, that, according to recent studies, female delinquents may have more psychiatric morbidity and worse outcomes than their male counterparts. Dr. Linda Teplin, legal researcher/psychologist at Northwestern University, reported that incarcerated females have higher rates of substance abuse, alcohol abuse, mental health disorders, and comorbidity with behavioral problems than their male counterparts. At present, there are no long-term, longitudinal studies that have assessed outcomes for females in corrections.

There continues to be a paucity of gender-specific interventions for female detainees, yet they continue at higher risk than their male counterparts for co-morbid mental health, alcohol, and substance abuse disorders. Female delinquents continue to be at extremely high risk for drug use, HIV, and violent
abuse. Often females’ needs go undetected, and there continues to be many barriers to treatment. These difficulties will continue to minimize the likelihood of female delinquents participating as active members of society and being helped. Longitudinal understanding of this problem continues to need investigation.

**Conclusion**

For all too long the needs of adolescent girls have gone without adequate attention, focus, and funding to the extent that boys have received. Girls need vocational and educational opportunities; girls also need women as mentors to assist them with the many challenges they face, along with opportunities to develop independence and interdependency. Lastly, girls need opportunities to have incremental successes upon which they can build for future successes.