

Teen Depression Through 3 Lenses: Young Adult, Parent & Clinician

Moderator is Susan Weinstein; with Mary Fristad, PhD, Emma, David, and Sheila

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WEINSTEIN: Thank you so much, Kat. Welcome, everybody. My name is Susan Weinstein. I'm the Program Director at Families for Depression Awareness. As moderator for today's program, it's my pleasure to welcome you to our teen depression webinar. We're especially excited about today's webcast because, in addition to providing information from a highly respected clinician, we're also bringing you voices of lived experience from both a young adult and parents' point of view.

After the webinar, I hope you'll take the survey to let us know what you think of this format. We greatly appreciate your feedback and we'll thank you with a free set of our depression and bipolar wellness guides for parents and teens. I'll share the survey link at the end of the webcast.

We've got other freebies for you as well. You can download a handout of the slides from this webinar screen. From the Teen Depression training page on our web site, www.familyaware.org, you can download an action plan template as well as materials for watching this webinar in a group and you can watch videos of our teen speakers talking about symptoms, treatment, coping, and parent reactions. We're working to produce a transcript of this webinar so please let us know if this would be helpful to you in increasing the accessibility of our programs.

If you know someone who might benefit from this webinar, please direct them to our website. We'll have it available for viewing on demand for the next few months. Finally, we hope you'll us reach more families and help more teens by making a tax deductible contribution to Families for Depression Awareness.

As you can see during the webinar, our panelists will talk about depression. What it is, how we can recognize it, and special concerns like self-injury and bullying, causes, treatment, getting help, and communication issues. Then I'll talk briefly about Families for Depression Awareness and the resources we offer. Finally, we'll have a question and answer period. Thank you to all of you who submitted questions with your registration. It's clear from those that many of you have specific concerns about your own teens or want to learn more to help the teens in your classrooms. We're still accepting questions so type them in and we'll answer as many as we can within our allotted time.

So let's meet the panel.

Today we welcome Dr. Mary Fristad as our expert presenter. Dr. Fristad received her Ph.D. in clinical psychology from the University of Kansas. She's a professor and a director of research and psychology services in the Ohio State University division of child and adolescent psychiatry. She's published more than 150 articles and book chapters addressing the assessment and treatment of

childhood onset depression, suicidality, and bipolar disorder. Learn more about Dr. Fristad's books and workbooks for parents, children, and therapists at www.moodychildtherapy.com.

Emma is a college student in the Boston area and a participant in our teen depression speaker's program. Emma has struggled with depression but is doing well now, thanks to good treatment and a supportive family.

We're also pleased to have David, Emma's father, on the panel. David speaks as a parent who has provided support to a struggling teen and learned about how to advocate for her healthcare and education.

Finally, we also welcome Sheila, whose son Colin is a participant in our Teen Depression's speakers program. Although Colin was unable to join us on the program tonight, Sheila shares her experience as the mother of sons with depression and as a parent who has survived the loss of a son to suicide.

Thank you all for being here.

So let's start with this. Sheila from your perspective, what's important for parents and teachers to know about how to recognize depression in teens, what to do, and how to talk about it?

SHEILA: Well, as you shared, I have five sons. Four have struggled with some form of mental illness from depression, anxiety, bipolar, and ADHD. And my youngest did lose his battle to depression. So for me, we need to talk about this because we need to educate not only teens but their parents about mental health in the same way we educate and talk about physical health. Sadly, mental illness carries a stigma and only through awareness and education can we help de-stigmatize society's view. And due to the stigma, so many don't seek the treatments for many reasons, from embarrassment to not wanting to be labeled. Many people, many teens suffer in silence or know personally someone who struggles. So by talking about this, we can help people recognize the signs of depression and we can give them the tools and the resources they need to seek help.

WEINSTEIN: That's great. I wholeheartedly agree. Dr. Fristad, I wonder if you could walk us through some of the context and information about teen depression.

FRISTAD: Sure. Depression is very common. By the end of their teen years, we know that 20% of adolescents will have experienced depression. And we know that depression is very treatable. More than 85% of teens improve with a combination of medication and talk therapy.

But sadly, we know that most people don't get help, teens as well as adults. So we know that nearly 60% of teens with major depressive disorder have not received treatment for their depression and that's really unfortunate because we know that untreated depression leads to very negative consequences. For example, we know that it is a precursor to substance abuse, academic failure,

bullying – both the bullies as well as the bullied – eating disorders, and as Sheila has personally experienced, the very, very painful outcome of suicide. We know that suicide is the second leading cause of death in 15- to 24-year-olds.

We know that depression begins early in childhood or adolescents. At least half of all cases of depression begin by the time somebody is 14 years of age and symptoms can start even before that time.

We know that depression is not the same as normal teen moodiness. Depression is really a biopsychosocial condition and a medical condition. It lasts longer than typical moodiness, and I like to say that it's a problem when it's a problem. And by that I mean it's when it interferes with a teen's life with how they're doing at school, how they're getting along with family, how they're getting along with friends. And what we typically see is a real change for a teenager. There are some kids who have the misfortune of having what we call double depression, where they've had kind of a low-grade depression and then the change is a little bit less notable, but typically we really will see a real change in functioning that indicates that somebody's experiencing a clinical depression.

WEINSTEIN: I wonder if we might talk a little bit about signs and symptoms of depression and Emma if I could call on you. How would you describe your symptoms of depression?

EMMA: When I first started feeling depressed, I was probably 14 or 15 years old and in high school. And the things I first noticed were a declining interest in things that I previously enjoyed doing, such as socializing, taking hikes, going out in nature, playing with my pets, listening to music, and even a decreased interest in eating and food in general. One of the things that really bothered me was a dulled sense of enjoyment. So there really seemed no point in going through the motions of life at all. It seemed very difficult with very little return.

WEINSTEIN: And David, who is Emma's father, were these the things that you also noticed or did you see it in a different way?

DAVID: I saw it in a somewhat different way. I want to start off by saying that one thing to keep in mind is that I didn't necessarily notice those signs as early as Emma said she did. One thing to keep in mind is to really be careful to be looking for signs because most people don't think their kids are depressed. That having been said, a lot of the things that Emma mentioned are true but the physical sign that I noticed in her case was serious weight loss, she didn't really socialize as much, she had less affection towards her friends and family, and she started paying less attention to her physical appearance. That was sort of a big red flag because that was a very dramatic change that I noticed at that time.

WEINSTEIN: And Sheila, are these kinds of things familiar to you or what did you see as the signs of depression in your sons?

SHEILA: For me, with four of them who've gone through it, they've kind of varied for each of them. My oldest in junior high was on top of the world and life was great and when he went to high school, he stopped socializing. He started feeling very overwhelmed with his school and with his passion for music. He started isolating himself at home. And he started having this whole unworthy feeling. Like he just wasn't good enough to be chop chair in the music thing and all this stuff. When he got diagnosed, interestingly enough, we learned about signs that he was showing that we had missed in his younger years such as excessive worrying, and the need to be perfect, and a glass half empty type of mentality. One of my other sons presented very differently through falling grades, very impulsive behavior, and substance issues. But then I also had a son who flew under the radar and really hid everything from us for years until he reached out because he was having suicidal thoughts. So I've kind of seen it all, and my son who died presented a lot like his older brother did but he went from a very mild case of depression into a very severe deep depression very quickly.

WEINSTEIN: Dr. Fristad, I think this shows a good range of experience, but would you talk about some more about signs of depression?

FRISTAD: Absolutely, and I think you've had three real experts just speak. So Emma, David, and Sheila all really hit on some very key points. If we talk through kind of all of the signs and symptoms, we think about a mood that changes and typically when you first hear of depression, you might think of kind of a child sad, boo hoo, crying in the corner, sort of a person. The other kinds of mood states can also be a very irritable kind of a porcupine quill shooting sort of an experience and what we see is that those moods really are persistent and they last a couple of weeks or longer and that's really I think what we were hearing from all three of our lived experts. And then what all three of them really talked about was that decreased interest and that is just a really key feature of depression. We heard particularly with Emma that she had some pretty profound weight loss and lack of appetite. In addition to that, it's common that we see changes in sleep, sleeping too much or too little, that energy levels and activity really change quite a bit. We heard from Sheila the unworthy, kind of that low, more than just I'm not good at this or I'm not good at that, but a really low sense of self-worth or feeling guilty for things that are completely beyond one's capability. We heard from Sheila about grades dropping. That's why we oftentimes get referrals from school because kids can't concentrate. They can't make decisions. We heard also from David about Emma not taking care of herself so well and oftentimes the somatic complaints that come with that. Tragically, we heard from Sheila about one son with some suicidal thoughts and then her son who died by suicide, and that, of course, is the very worse symptom of depression and one that we most definitely want to prevent as well as prevent the other symptoms that come with depression.

WEINSTEIN: So there are a couple of special circumstances or special concerns that we'd like to draw attention to. For us, those are bullying, self-injury, and suicide risk. I wonder if, Dr. Fristad, you'd be able to talk about those and also the causes of depression and treatment.

FRIESTAD: Sure. So when we think about depression and bullying, we want to make sure that kids are safe at school, at home, and in transport between those two places. Kids who are the bullies oftentimes are doing that out of very feeling miserable inside and they're going to make the world outside be just as miserable as they're feeling inside. And so we really want to focus on having behavioral consequences but to help them develop empathy and to find other more appropriate ways to deal with their negative emotions and issues of control. For those who are being bullied, we want to lend them support and understanding, a perspective that things will change and to give them strategies for coping and to really be able to answer back to the bullies.

Another complication with depression can be non-suicidal self-injury and we know that a remarkable number of teenagers self-injure at some point in their life. This happens with both boys and girls. Really no ethnicity is immune from it. And this is something that is just very, very scary to parents and teachers. So if an adult is suspecting that there's self-injury, you want to respond with calm concern to assess the immediate injury, the severity of the injury. Ask what we call respectfully curious questions. Could you tell me how you got that mark on your arm? That sort of thing. And then engage the young person in identifying the next steps. Typically that means who are the parents, if it's for example, a teacher who becomes aware of this, making sure that the parents have become aware and to help the family find a provider for care.

In terms of suicidal feelings, it's very important to ask if somebody is feeling that way, if they're thinking of hurting or killing themselves. The fear has been in the past that if you ask kids about suicide, you might be planting ideas in their head. We have no evidence that that happens, but we do have evidence that if nobody asks the question, kids can suffer in silence. So listen, look, are kids are talking about hurting themselves or how they might hurt themselves? Are they obtaining weapons, pills, or any other lethal means? If somebody is giving away their prized possessions, if they're making a last will and testament, those are some of the last signs that we might have to be able to act. And if that's the case, we never, ever want to leave that person alone. We want to do what we need to do to get them support as quickly as possible.

In terms of causes of depression, we know that mood disorders are very inheritable. Twenty to 50% of children and adolescents with depression have a family history of depression, and I would say that the younger the child is when diagnosed, the higher the likelihood of an immediate family member also having a mood disorder. I like to take what I would call a three-generational genogram whenever I'm evaluating a child, so I want to know about mom and dad, aunts and uncles, grandparents, and I want to know if there's a history of depression, bipolar disorder, substance abuse, anxiety, and also what kinds of psychosocial experiences have kind of also run through the family. Has there been domestic violence? Has there been other kind of stressors in the family?

We know that persons with depression have different biology; the structure and the function of their brain are different. And as we're doing more and more studies with brain imaging, we're learning more about that. We know that severe trauma, particularly sexual and physical abuse, can really

trigger depression in a child, as well as other stressful life events such as illness or the loss of a family member. So we really think of depression as a biopsychosocial kind of a disorder and one that if you have higher genetic likelihood, it might take a smaller stressor to really push somebody into depression.

In terms of treatment, the good thing is that we increasingly have treatments that have been proven to be efficacious. When I'm making a treatment plan with a family, I like to think about if the symptoms are in a mild, moderate, or severe range. If symptoms are in the mild range, typically I would prefer to start with talk therapy, with other components of intervention, including paying a lot of attention to sleep, eating, and exercise. All of those can really matter. If somebody has a very severe depression, we probably start with medication right away. And if they're in that mid-range, then I really want to understand where the family and the young person's preference is. Do you prefer to start with meds? Do you prefer not to start to start with meds? People tend to have opinions about that and it's best to really work with the person's personal preferences. Again, it's on the mild and the severe side that I have kind of stronger feelings about where the treatment should start.

In terms of talk therapy, one example is cognitive behavioral therapy, the most research has been done with that. There's also another form of psychotherapy called interpersonal therapy that's been proven to be beneficial for teenagers with depression. In terms of medication, there are a number of medications. Most commonly what are called the SSRIs or Selective Serotonin Reuptake Inhibitors that are used. They tend to first improve the physical symptoms of depression. So the sleep, the appetite, the concentration, the energy level, and then later on comes the improvement in the thinking and the mood state.

It can take some time to find the right medication and dose and it's important to monitor both for positive effects as well as side effects. It's also particularly important - this is a bit more common for teenagers than children - to understand that alcohol and illicit drugs can interfere with prescribed medication. So it's very important to have an honest discussion about the amount of alcohol and drugs that a teenager might be using.

But getting back to other interventions. It's important to know again: sleep, eating, and exercise. Those are kind of three keys. Most teenagers don't get enough sleep, and we all know that when we're a little sleep-deprived we can get irritable. And so starting with really paying attention to sleep is a good place to begin to see if you can make some improvements. In terms of eating, we're learning more and more about the role of nutrition in treating mood disorders as well as other kinds of psychiatric disorders, other behavior and anxiety disorders, and the more balance and healthful nutrition as well as the Omega 3 fatty acids typically from supplements can really help with fighting off depression. And then exercise. We do know that aerobic exercise is an excellent anti-depressant and can make a sizeable difference in the severity of symptoms. So those are all important aspects to be aware of.

WEINSTEIN: And certainly different treatment approaches work for different people, depending on severity but also on personal preference and beliefs, but let's ask people who are here. Emma, what treatment has been effective for you?

EMMA: So I kind of think of the treatments that I have undergone and worked in three categories: therapy and more biological, so medication, that kind of process. And then finally things that I kind of worked out socially. So I think that for me psychotherapy – which I've been in for about five or six years now – has really given me, well, in many circumstances has kept me alive. If I was feeling suicidal or like I was going to hurt myself, it was very helpful for me to have someone to turn to, a therapist who I could talk to about that. But the real turning point for the better came for me about a year and a half ago when I did get the correct dose of the correct medication. So from a biological standpoint, I think that really got me out of the depression, the deep depression that I've been in. And I think it's very important to try medication that maybe you have negative connotations to, whether stigma around taking, because those can be very helpful. You really never know, one thing might work for someone but something different might work for someone else, so I think it's important to keep an open mind. And then thirdly, perhaps most importantly, was coming to the realization in my own mind- and this took many years – that I wasn't to blame for this. And that this wasn't something that should have stigma around it, so not necessarily my going around and telling everyone I meet what had happened, but realizing that I could be honest with myself and just really realizing that there were things to live for, and constantly reminding me, myself of those reasons to live.

WEINSTEIN: David, how did you know when treatment was working?

DAVID: Well, the most obvious sign was she was less isolated. I mean from a very real, from a physical standpoint, sort of being willing to attend more family events and let on with friends and things like that, and also emotionally less isolated. There were times when she'd want hugs and attention, things like that. And as she was sort of coming out of it, she was much more conversational with me, my wife, or her brother, who's a few years younger than her. So that, in my mind, that was really a lot of it.

On the other hand, I sort of want to add to what Emma said, was that you really need to listen to the kid and that's different depending on how old they are, but if the child says, I don't click with this therapist or this medicine isn't helping me. I think one of the things we've learned is it's very easy to sort of discount that either because they're young or because they're having trouble that they don't necessarily know what they're talking about, but what we've learned is that you really do need to listen to what the patient or child is saying about that.

WEINSTEIN: That's really important. Thank you. Sheila, how does Colin maintain his wellness?

SHEILA: He started out with both medication and psychotherapy. When he first started out, he was on the wrong medication, so he had some bad reactions. So it takes time to find the right medications sometimes. Thankfully we did. He has decided at this point that he is trying to go off medication so he's just doing psychotherapy. So that's been very beneficial. He has enjoyed the psychotherapy and found great comfort in it.

WEINSTEIN: Great.

DAVID: Susan, can I add one thing?

WEINSTEIN: You bet.

DAVID: David again. One thing, important thing that I forgot to mention was that when Emma really started talking about doing things in the future whether it was school, travel, that kind of thing, I think that's a very important thing to keep an eye on is whether the child has any focus on anything, any goals, anything that's going on in the future. And when she came out of it, that was a big telltale sign.

SHEILA: And Susan, can I can I add another thought?

WEINSTEIN: Sure thing, Sheila.

SHEILA: We talked about the psychotherapy and the medication, but for us with each of our children that have gone through this, a big factor in treatment is the environment. I think sometimes kids aren't always in the healthiest of environment for them. For one of our children, we were sending them to school like everybody did out in our area and it wasn't a good environment for them, and so we changed school, and it was a godsend. So I think it's very important to know what environment is healthy for your children and what is going to help them the most.

WEINSTEIN: We do find sometimes that treatment doesn't work and it turns out that the teen has misdiagnosed. So this is something we like to keep on the radar screen for parents and others. Dr. Fristad, can you tell a little a little bit about the different between depression and bipolar disorder and also some people want to know about bipolar I versus bipolar II.

FRISTAD: Certainly. And this is something that's commonly confused and also even when you go to see a clinician. So major depression is really when you have that constellation of depressive symptoms. Bipolar disorder is a combination of the highs with the lows. They can happen at the same time, which is very confusing for families, or they can really cycle. So Bipolar I is when you have the full mania, when you have kind of what I call a "too muchness." You are full of energy. Your mood is too high. You have grand ideas of what you can do that are quite unrealistic, often times not safe. Don't need to sleep as much. You're just kind of in ultra go mode. And then you

alternate that with depression. And that's Bipolar I. Bipolar II is a milder version of mania, a kind of hypomania, and in combination with depression. The reason that's confused by families as well as clinicians is that if people are hypomanic, they are not concerned about that. They feel kind of good. And it's easy to forget that there might have been some problems in the hypomania when you come in to see a clinician when you're depressed and so, if a careful history isn't taken, the family might be aware of the depression but might have kind of forgotten about that earlier mania or hypomania. And the reason that that really becomes important is that the medication treatments for bipolar disorder are different than the medication treatments for depression. So we really move to atypical antipsychotics or mood stabilizers for bipolar disorder, not antidepressants. So that's very, very important to know. So again, it's really important to have a very careful history when you're doing that diagnostic assessment. In either case, the talk therapy can really complement the medication, as can some nutritional interventions.

WEINSTEIN: Sheila, I understand that one of your sons was misdiagnosed. How did you come to realize that you needed to seek another opinion?

SHEILA: It was my son Colin who I talked about with the changing the medication. When he first went on the medication, it kind of sent him into a manic state and he just thought everything was great. Quite honestly, Colin was in crisis when our youngest was going into crisis too, so we were working with that. And when my youngest died and we were trying to get everybody more help, we went to doctor locally – he had been diagnosed at school – and when we went to a doctor locally, they pointed out to us that this medication was obviously not working and that he was bipolar and not just suffering from depression.

WEINSTEIN: Dr. Fristad, how do people get help for a teen? When should they, what do they do?

FRISTAD: Sure. As I said earlier, it's a problem when it's a problem. So if you're seeing interference at school, at home, with peers, it's time to get help. And certainly if you're hearing of any suicidal thoughts, behavior, thoughts, talk, you want to get help right away. Symptoms by definition have to last two weeks or longer. I really can't say I've ever met a family who comes in to see me for an appointment because my son just hasn't been right for the past 10 days. It takes longer than that to really recognize that there's a pattern, a problem, and then by the time you kind of get around to getting the appointment and getting in to see somebody, I really have never seen anybody unless they presented with very, very acute symptoms who come in immediately. Typically, families wait months or longer before they kind of say, this is just too much. But by our definition, if somebody's had symptoms of depression that have really coalesced for two weeks or longer, they've really met our diagnostic criteria. But again, I think the important feature is it's a problem when it's a problem. So when you're seeing interference with life, it's time to do something about it.

In terms of where to get help, we do know that our mental healthcare system is really overburdened. There are about 7,000 child and adolescent psychiatrists in the country and pretty much every

location will say that they are underserved. There are other professionals – other than psychiatrists – who are able to diagnose and treat, but in terms of medication, that would really mean coming to a child and adolescent psychiatrist and, in some communities, nurses, advanced practice nurses, and then certainly primary care physicians. So those are some of the options. In terms of psychotherapy, that is most commonly provided by psychologists, social workers, mental health counselor. The key is that you want somebody who is really familiar with that age group, the age of the child you're bringing in, be that child five or 10 or 15 or 20. And that they have familiarity with what mood disorders look like. Those I think are really key.

In terms of who you might ask, now this is where – and you heard from our lived experts already – we face the issue of stigma. So, if you have a problem with your knee in a sports injury, people have no shame in saying, “Well, what orthopedist do you go to?” But people don't have that same level of comfort with, “My child's been talking about suicide. What mental health professional do you go to?” People just don't have that same level of comfort. There's a lot of shame and blame and guilt that parents suffer from when their child is suffering. So going to a primary care provider to get referrals is a good idea, talking to folks at school, the school professionals – the school psychologist, school nurse, guidance counselor – and then really widen to your degree of comfort. It's impressive to me that when people do open up how often they are met with people who really do understand because they know other people who also have been dealing with significant mental health issues. So neighbors, friends, religious leaders, calling to a local mental health clinic, hospitals that have departments or divisions of child and adolescent psychiatry, and then certainly Families for Depression Awareness have really great resources, and I know that Susan will be talking more about that toward the end of our time together.

In terms of what you should be looking for in an evaluation, good treatment really depends upon an accurate diagnosis. So you want to rule out other factors. You want to know that you have checked out physically so that it's not something like a thyroid problem or any other kind of physical health condition. So if somebody has mono, I really cannot use psychotherapy to treat their mononucleosis. There might be a learning disability. So if kids are struggling really only in the school setting but no other setting, then I start to think there might be some learning issues going on. So a thorough evaluation should include that family history. We talked about that three-generation family tree, some history of how the child has developed, how they've done in school, what their relationships have been like with their friends and family, what kind of stressors they've experienced, and what their medical history is like. I always want to know the onset and offset of symptoms, if they relate to allergies and asthma meds, any head trauma. So, again, putting everything together in a comprehensive sort of way.

Treatment should absolutely include education and support and I think Families for Depression Awareness provides really, really good resources for that. Support groups are listed on the familyaware.org website but also check with your religious organization, other social groups, youth centers, Boy Scouts, Girl Scouts – those sorts of groups can also be helpful.

WEINSTEIN: Thank you. And so many of the questions that we got on the registration forms were about talking to teens. How to start the conversation, what to say, what to do when they won't cooperate, what do you do when someone is not so young anymore, when they're over 18, when they're over 24. Can you approach some of these issues and help people understand?

FRISTAD: Sure. So you want to start by being supportive. I thought some of the earlier comments that we heard from the lived experience experts on the call were really helpful, and David's comment about listening to your teen because the kids who are experiencing the depression need to know that they have what I call "voice and choice." That their voice is heard and that they should have some choice in what their treatment is because, quite frankly, if you don't want the treatment you're getting, you will find a way not to use it. You can spit out the medicine. You can not talk to the therapist. And that's really not useful.

So for parents, for teachers, I would encourage you to really be supportive. Parents, it never hurts to tell your child that you love them, to talk about their good qualities and strengths. One of the exercises we do in our treatment is an exercise we call the symptom-self exercise: we have kids list the symptoms of depressions that they've been experiencing but then also list characteristics of themselves because they are more than their depression. We really want them to understand this is who I am as a human being and then there's these symptoms of depression that I've been experiencing, but that's not me. That doesn't define who I am as a person.

A motto that we have in our treatment program is "it's not your fault but it's your challenge" and I think you heard that from Emma earlier. She really had to come to the realization that it wasn't her fault that she felt so crummy. I mean nobody asks for the horrifically bad feelings that come with depression. They are simply there. So your job as a parent is to keep your child healthy, to keep your child safe, and to stay connected. At the same time, kids typically don't want their parents turning into the junior analyst and trying to understand absolutely every cause of their feelings, but for the child or teenager to know that the parent is aware, concerned, and supportive I think really goes a long way. And you see on the slide now sayings that the parent might have that really may aren't so helpful and what some more useful kinds of responses might be.

WEINSTEIN: For example, if someone who is not a parent is trying to encourage the parent to get some help for the kid, if the parent says, my daughter is going to be mad at me if I say I think she has depression or I think I want to take her to get help. How might you reply to that?

FRISTAD: And it might be the adolescent will put up a fuss but what you can say is I've really been concerned. For the past over a month you just haven't seemed yourself. You've been staying in your room. Nothing seems to bring you any happiness. Your grades aren't doing so well. I hear you up not sleeping well at night. You haven't been eating as much. These are all very concerning signs to

me and I think it's a problem beyond what I know how to help you solve and we need to go see somebody to help us with us.

WEINSTEIN: And one of the things that we hear a lot of is when someone is a school counselor or a teacher and they're trying to talk to the parent who is not recognizing that there is an issue or is so taken with the stigma of the whole thing. I don't want my kid taking medicine. What are some things that people who are not the parent can do?

FRISTAD: Sure. And to say, I don't know that your child needs medicine, but what I want to tell you, Mrs. Jones, is that watching your daughter at school, it's breaking my heart. She used to be a vibrant student. Her assignments were well done and lately I've seen a young lady who comes into my classroom looking like nothing matters to her anymore. And the quality of her work has gone down, but she just looks miserable in my classroom. I don't see her laughing and joking with her friends anymore. I see her kind of isolating. She's walking in and out of class by herself, not with her group of friends like she used to. All of this has me very concerned. I don't know that medicine is the answer but I would really ask you to take her for an evaluation because I'm seeing signs that make me concerned for her well-being.

WEINSTEIN: So by spelling out the signs and making it real for the person --

FRISTAD: Right, right. The teacher isn't going to save them, the plan is. But the teacher can certainly share the behavioral observations that are distressing.

WEINSTEIN: What else can you talk about when you're not the parent?

FRISTAD: So again, you can encourage them to get help, express those concerns as we said about the signs of depression. It's clear a school professional can say, I'm not a mental health professional. I'm a school teacher. But I'm seeing things that make me concerned. It's really useful if the school has a list of mental health clinicians that they've had good experience with and then again if you're a teacher in a building, you probably before you talk to the parent, chances are really good that you've been checking in with colleagues that, am I the only one who's noticing this or other people noticing it, too? And then you could be able to say, it's not just me but her social studies teacher has noticed the same thing and in the lunch room, blah, blah, blah. So I think there are ways of being able to kind of bring in some extra observations.

WEINSTEIN: So now let's talk about some ammunition for the parents when they get up the gumption to talk to the teen and the teen doesn't cooperate.

FRISTAD: Sure, sure. So and here you see a long laundry list of the kinds of things that sometimes teenagers will say. So let's go through some of these. "I can handle these myself. This will go away on its own." "Well, the problem, sweetheart, is that I've watched this for the past six weeks and I've

watched how you haven't pulled out of it on your own. I'm really aware of depression because I've experienced depression myself and I know what it's like and I know I've not been able to pull out of it on my own. I'm seeing those same kinds of signs in you and I really need to take you to see a professional now." Or maybe the teenager says, "Well, I'm not crazy." You say, "I agree with you 100%. I don't think you're crazy either but I do think you look really miserable to me. And people don't need to go through life being miserable. I would ask that we approach this together. I'm not blaming you. I'm not blaming myself. I'm not blaming anybody but I'm looking at you and I'm seeing a very, very unhappy person and I know that there's treatment for that. I want to help you get that treatment." Or maybe the teenager says, "I don't want to be locked up in a hospital" and you can say, "I don't want you to be locked up in a hospital either. That is really not step number one. Let's go see what number one is in terms of treatment." Same kind of deal if they say, "Well, I don't want to take medication." "Medications aren't necessarily step number one. Let's go talk to a professional who can tell you what the array of treatment options are and you can decide from those what you want to start with." "I don't want to talk about this." "You don't have to talk to me about this, but I really do want you to go with me to see somebody who can help us determine the size of this problem and what we can do about it." So I think those are all some kinds of things that a person can say.

WEINSTEIN: Great. So I like that you're really able to normalize it and put it in perspective and keep on the positive and trying to focus on them feeling better. So Sheila, if I can bring you into the conversation. I'm wondering what were your experiences with your teens. Did you have concerns about them getting diagnosed? Were you able to talk with them about their depression? What kinds of communications issues did you have? Are there any of those that we can learn from?

SHEILA: I think I might be different from some. I didn't have concerns being that we have the family history. So I had been aware of mental health issues. I was talking to my kids as they, I guess with my first one it was harder because it was a surprise. I guess I haven't thought of that. You think of your kid getting everything but a mental health issue. But we really, we have open conversations with our kids. We try to hit on the fact that this is genetic. This is not your fault. If you needed glasses, if you had diabetes or whatever, we'd be doing something and this is just like that, so we've tried to have open conversations. It's very hard because not all of mine have been compliant and they fight it. A lot of it because of the stigma and it's very hard to overcome the stigma because it does surround us. Does that answer it well enough?

WEINSTEIN: If you're comfortable with it, I'm comfortable with it. Did you have strategies for getting over any communications barriers with them?

SHEILA: No. Just a lot of love and a lot of conversations and a lot of patience with challenges I never thought I'd have. I think, sadly, when you lose one to the disease, not only do your friends and your family but your own children, everybody seems to be much more compliant and much more open and less judgmental because I think through my life experience, the people who are in

my life got a sharp awakening and education to mental illness. So through my tragedy, people got educated and it helped my cause with my other children and my friends who are having children that struggle.

WEINSTEIN: David, what kind of concerns did you have and how were able to talk with Emma?

DAVID: My first thought was, “So what did I do wrong? What did I do or not do as a parent when she was a baby, when she was older,” and although there may be some element, nobody’s perfect. Obviously depression is a mental illness. It’s not anything that, any particular thing that you did but it is hard to sort of think of that in the moment and the hardest part was really not knowing what to expect. You don’t know if this is something that can be treated very quickly or whether it’s going to be a long haul or whether it’s going to be, how difficult it’s going to be or what people are going to think. So not knowing what to expect into the future was very difficult for me. And the other part of it was there are good providers and there are not so good providers. And it’s difficult to have your child be helped by somebody who doesn’t necessarily get it. One word of advice would be to really advocate for your child and you’ve got to remember that you know your child a lot better than any of these people do and don’t be afraid to pipe up, especially if the kids much younger and it’s within your purview to do that. But really interject and say, look, you’re on the wrong road with this, or this is some experience the child had as a child that might be helpful to you – sort of all the background – but also advocating and letting others know really who your child is. I think that can help them and as I said before, if they’re not clicking with the provider, really give them the option if you have the means to switch to somebody who might be helpful.

SHEILA: Susan, can I add something?

WEINSTEIN: Yes, please.

SHEILA: I love what David says about advocating and it is, it can be very challenging to find the right counselor for your child. But you also need to advocate in your child’s school. I found through our personal experience that the school unfortunately wasn’t properly staffed and properly aware, so when you have a child in crisis, you don’t always get the understanding and the compassion and the services that you need to help your child through. So not only with the doctor but in school it’s important to advocate.

DAVID: I whole-heartedly endorse that and unfortunately college is not much better than high schools. They have their own sort of PR political agendas about how their students are doing. So you really have to go into all schools, I agree all schools, with a healthy dose of skepticism unfortunately.

WEINSTEIN: Okey dokey. So Emma, let me swing back to you. Of the things that your parents did or said, what did you find to be helpful or supportive?

EMMA: So when I was first diagnosed with depression, my friends - completely well-meaning - were trying a lot to reassure me that everything would be fine, but it got to the point where that almost seemed sort of judgmental like, oh, you can do this, you'll get through this. Of course, it will be fine. So I think it's really important, it was important for me to hear my parents have a balance of reassurance but also validation like, for instance, OK, you're going through this really hard time. It's going to be OK. You're going to get through this, which ended up thankfully being true. I think it is for almost everyone eventually. At the same time, being validating and saying but I know it's really hard for you right now. I know, I understand that you're saying that you haven't been sleeping. Maybe you're not doing as well as on exams as you were and that must be really difficult. So that balance of like optimism but also validating how difficult things were for me by echoing mostly the things that I was saying was really helpful. I know that we talked earlier about the parents, the fine line that parents have to play between not being therapists but also making sure they're involved. So for me, my parents started out really trying to problem-solve and they're both being thoughtful and saying, well, here's something you can do, which added a lot of pressure, I think. It kind of went back to the reassurance. Like, oh, well, if you do this, then you'll get better. You'll feel better. And what really ended up helping was their listening and their realizing, OK, she's working with the therapist. She's getting some help and sort of sitting back and listening over feeling like they have to really solve my problems right there because mental illness and depression very obviously a complex issue. So finding someone to listen to that's not going to, that doesn't just jump in and say, well, this is what you should do, that's what you should do. As difficult as that might be for parents who obviously want to solve their child's problems, I think listening and validating, they're very helpful for me.

WEINSTEIN: Great. And that certainly loops back to what your father said earlier and also what we've heard from the others. I think that's tying it up really well, so thank you. I'm going to take about five minutes and talk about Families for Depression Awareness and then we will come back and have questions and answers, even more important. And after that, I'll send out the link to the survey so that you all will be able to tell us what you think of the program and also receive a free set of depression and bipolar wellness guides for parents and for teens. So stay tuned for all that. I want to thank all of our panelists. This has been really interesting and fun and engaging and so I really enjoyed and I thank you for being here and I learned things. So I always like that, too.

Let me talk briefly about Families for Depression Awareness. We are a national nonprofit organization. We provide education, training, and support in helping families recognize and cope with depression and bipolar disorder because we want people to get well and we want to prevent suicides. We're very much about the family; our mission and philosophy tie together because we believe that depression and bipolar disorder affect the whole family. If one person is affected with depression, it could mean another person may have, one of the kids might have a higher risk of depression. It could also be affecting the other spouse, who is trying to be supportive while taking

care of the rest of the family. Everybody has needs and it gets treated best when everybody gets the care that they need.

We have loaded up our website with a lot of resources and information for you. It's in a variety of forms. We have expert interviews. We have family stories. We have podcasts. We have these webinars. Also, the good news that within the next couple of months we'll come out with an entirely new website and it will be much easier to find what you're looking for but in the meantime, I recommend using the search bar. We have an audio podcast series that has a lot of key issues that are succinctly discussed, like how to talk within your family, talking to your teen about depression. We have a variety of tools, one of which is the mental health family tree, which really helps the clinician like Dr. Fristad because you can go through this and enter behaviors of selected members of your family. You can go back generations. It helps clinicians see where there are patterns and that's especially useful for diagnosing bipolar disorder.

We also have other webinars. We have "When Depression Isn't Getting Better," which is about treatments. We have a program about bipolar disorder. We've got one coming up on coping with stress and depression for adults. There were a few questions about what happens when medication isn't working. What happens when therapy isn't working? And I really recommend that you take a look at this depression treatment program that we have on our website.

We have workshops that can be presented by you or by us if you're in Massachusetts on teen depression, so a version of this program that you just heard, and the coping with stress and depression workshop is very useful in workplaces and community groups. We have a variety of brochures: Coping After a Suicide, Coping with Stress, Helping Someone Who Is Depressed. So we have a series of brochures. But we also have wellness guides and this is what you're going to get when you provide us with the feedback on the survey, but the depression and bipolar wellness guide for parents and teens is especially useful because it allows sort of a neutral environment for the teen and the parents to work together on defining wellness and then tracking the progress so that when you are in treatment, you're better able to engage with the provider about what's working and what isn't. It has a lot of information also about depression and bipolar disorder so that everybody gets that baseline of information that they need to be able to address how depression or bipolar disorder is impacting your family.

We also have a program that you can download, a wellness analyzer, that helps you track your treatment because when you go to the provider after two weeks or a month and they say, how's it been going, you're probably good if you remember the last three days. So having something that can help you track how your moods are going and any kind of reactions you're having is invaluable when you're being treated.

One of the things that we've introduced here at Families for Depression Awareness is that for Massachusetts families we can offer care consultations, where you meet with a clinician who can

help coach you on dealing with getting someone the treatment, how to work as a family, and you get an action plan that you work out as well as referrals to clinics and programs. I encourage you if you're in Massachusetts to check that out.

We also are involved in an advocacy blog called Care for your Mind. Right now we're doing an amazing series on perinatal mental health, so depression during pregnancy and postpartum. We've got a range of people participating including those with experience and advocates and clinicians and even a Congresswoman has contributed to the program. So head on over to careforyourmind.org and, as we say, join the conversation.

There are a variety of resources that we have listed on this slide where you can find more information beyond our website and also find some support groups and outlets for advocacy. There's a whole lot you can learn and there are ways you can get involved.

I really would like to thank our panelists tonight. Dr. Fristad and Emma, David, Sheila, and members of our advisory board for helping us prepare these materials. Dr. Linda Zamvil, Dr. David Fassler, Dr. Carol Glod, Dr. Mitch Prinstein, and Dr. Fristad. Thank you again. And also, we would not be able to do this programming without the generous support of the George Harrington Trust, the Rebecca Pomroy Foundation, the Adelaide Breed Bayrd Foundation, the John Donnelly Trust, TJX Foundation, the Thomas Anthony Pappas Charitable Foundation, Hart Foundation, Samaritan Foundation, and the Bennett Family Foundation. And I would be remiss if I failed to mention our thanks to people like you who are listening who make contributions to support the work that we do. So thank you.

All right. That was my piece. Let's head over to the questions and answers while we still have several minutes we can do. And here's what I hope is a quickie. Dr. Friestad, is depression more prevalent in one gender than the other?

FRISTAD: It is when you get to adolescence. In childhood it's about a 50/50 deal but once you hit adolescence and puberty, which is happening earlier and earlier particularly for girls, the rate in girls doubles. And so we do see a lot more depression once you get to those adolescent years.

WEINSTEIN: And some people are concerned: do cell phones and video games increase the risk of depression?

FRISTAD: I don't know that those per se. I mean any tool can be good or bad and we know that it's very useful to have access to communication and to recreation. But I would make a couple of points about that. One is that if you spend all of your time indoors on a computer, you aren't getting outside and getting physical exercise. You're not getting Vitamin D from sunshine. You're not engaging in the world in a way that can be very good for your mood. So it's not that playing on a computer or being on the computer all the time or playing video games is bad per se, but it's what

you aren't doing because you're doing that. In terms of social media, we certainly have lots and lots of examples of how kids can be very, kids and adults can be very, very crass and say things that they wouldn't say face to face but they will say on social media. And so for all of us, I would encourage us to have interactions with people in real time over simply having interactions with people via social media.

WEINSTEIN: When a parent is noticing that their kid doesn't leave their bedroom or their computer or video games, or is otherwise isolated, how much should a parent push or encourage a teen's participation in activities?

FRISTAD: Right. It depends upon a couple of things. One is that certainly for a lot of kids these days, much of their social life is wrapped up in how they connect with others on social media so they might be very, very socially interactive but they might be doing it all from their bedroom. I think it's useful to have some rules around interacting within a family, like you can't just live in your bedroom with your door shut. We'd like to see your smiling face down in the family room, down in the kitchen. Let's have some conversation. This is one of the reasons that having family meals together is a really good thing. Having people participate in the preparation and the clean up after a family meal are just ways to make a normal habit within the family of interacting and so I would encourage families to think about how can we just make as a general practice ways to interact and have real communication, real face to face communication.

WEINSTEIN: We got this question in several variations but I'll give it to you this way. How do you distinguish between someone having a mental health condition and just wanting attention or being manipulative?

FRISTAD: Sure. So I don't know many kids who would want to embarrass themselves in front of their peers by acting unusual. There's nothing like not wanting to look weird to regulate behavior in a school setting. So when kids are showing signs of distress in a school setting, I would see that as a very clear sign that there's something really wrong. And if the only time they're acting out is whenever there's a math test because they hate math, then one might think, huh, maybe they're trying to get out of their math test, at which point you might need to deal with why is math so difficult? But I would really go back to the "it's a problem when it's a problem" and if you're seeing kids struggling with their relationships within the family, with their peers, at school, in their school performance, that would suggest to me that there's something not right that needs to be figured out.

WEINSTEIN: How can parents help and how can schools help the kids dealing with depression when the parents also have depression?

FRISTAD: That's very, very common. And so as part of any good evaluation, getting a family history - you saw with the Families for Depression Awareness, the really good family tree. I talked a little bit about what goes into a good evaluation. If in the process of evaluating the child, the parent

says, oh, wow, that sounds like me, great, well, not great, but great that there's recognition because then part of the treatment plan for the child is likely making sure that the parent also gets the help that they need for their own mood disorder and that again might be a combination of medication, therapy, other kinds of we talked about environmental interventions, maybe. Maybe the entire family is just pushing too much. Maybe we need to think about how to relieve stress in the family across the board or whatever the circumstances are. So addressing the mental health needs of all the family members can become a very important part of treating the child.

WEINSTEIN: So for all of us, raising a teenager can be challenging but mental health issues can make it even more so. Sheila or David or both, what have you as parents done to get support for and take care of yourselves?

SHEILA: You go first, David. Go ahead.

DAVID: I was going to quickly say that I mean depending on what your social network is and your family network is and who's around for you, my wife and I find that helps. We find it's helpful if it's like one or two key people who know what's going on and if you can call them and just say either I need a break or just to even have somebody to spout to. That is very helpful. You don't want to tell everybody you know what's going on out of respect for the child's privacy. But usually some family member who knows enough that you can really rely on them and they're usually happy to help. The other aspect of it and we wish we'd done more of this was even though you're relying on depending on what your family situation is if you have a partner or a spouse in this with you with the child, is to sort of, you know, go and exercise yourselves and your instinct is to sort of all stay together as a family and hunker down. But I found that it was helpful to say, OK, as a wife, partner or whoever it is, I'm going to go for a run now or I'm going to go see a friend or something for a short period of time and recharge. You can do that in a way that's not disrespectful to the other person but just really gives you a chance to get a recharge for yourself.

SHEILA: I would completely agree with what David said. When you're dealing with the child with mental health issues, the home environment often can be very hard and stressful and challenging and it can be hard on the marriage. So as much as we, my husband and I, depend on each other through this, I think a lot of times we needed an outlet with a trusted friend, somebody you completely trust where you had an outlet to unload and share and cry and get some input or output. So it was very important to have one or two trusted friends that we could both turn to to just kind of unload and, again, taking time for yourself to exercise. I found time when one kid is making things rough and you just need a break, realizing parenting still can be a lot of fun and do something fun with another child. But the friend is important.

DAVID: The other part of that, just so people understand, is that you'll often find people whose children, even if it's not depression, have some issue whether it's depression or something else and you can learn to sense some of these, other children see them. That they're having a hard time and

that's often another parent to talk to and talk about the different experiences you're going through. It might be similar to what they're experiencing.

WEINSTEIN: So Emma, in talking about friends, someone wrote in and said, they want to know whether they should tell a friend about their depression or bipolar disorder. What's your experience or what kind of things would you suggest to someone to consider before they tell?

EMMA: So I found it very difficult not telling any of my friends which especially early in high school when I myself didn't really know what was going on and didn't have a diagnosis and really didn't know why I was feeling so horrible. And the problems I find with not telling anyone was mainly people whether friends or teachers or even relatives they ask too much like too many questions. They're meaning well but concern, what's going on? Why aren't you at all these parties? Why aren't you doing well in school? All out of concern but it got a little overwhelming.

Or on the other end of the spectrum I found people, some people just wouldn't ask anything. It was really obvious that I was struggling and part of me was kind of like, oh, why can't you read my mind? You're my best friend and you can't even tell there's something wrong with me and that would get really frustrating. So I know it's definitely hard to tell people and I think it depends on who your friends are and what kind of relationships you have with your friends.

I'd say for a teenager, I think definitely for me that was especially difficult as a teenager because you're still trying to, everyone is still trying to find their place and what do I want to do? Who do I want to be? So everyone has a lot going on. But what I found helpful was approaching one of my friends who I spent a lot of time with in high school and starting out by saying I don't, I'm not exactly sure how, what all these feelings mean that, when I'm feeling really down and even if you only give that amount of information and you don't really go into depth with that person, the chances are that if they're in your classroom and they're a teenager, they probably have had some sort of self-experiences and have gone through something even if it's not clinical depression or mental illness and I think that's really important to have someone who knows that you're not 100% that you're not feeling necessarily the best that you've ever felt because that way people just, at least you have someone who can talk to and say, oh, man, I just failed that test, for instance, and they'll know you're not just being really nitpicky with your grades and maybe there's something else that's going on.

I've also had experience where I've told people who I didn't know quite as well and it sort of backfired. There is a lot of stigma especially in high school and even in college around mental health and especially when I was really struggling that kind of threw me off a little bit thinking, oh, I am, reinforcing the stigma, oh, I am bad because I told this person that I was depressed but eventually you'll realize if you tell people you know well enough that you know are really your friends, they'll respond. They'll be helpful. Most likely, it's also a way to find out unfortunately who your real friends are and you really know, who's really not going to be helpful.

WEINSTEIN: I want to ask a couple of medication questions because people have sent them in. Dr. Fristad. Should medication be a last resort for treatment?

FRISTAD: Last resort maybe isn't the phrase that I would use. As I said earlier, I wouldn't start with medication unless it's a more severe presentation. Or for somebody who for whatever circumstances that's really the only kind of intervention that they will be able to or be willing to access. But I also then wouldn't totally drag my feet if you've been trying psychotherapy. You've been trying other kinds of environmental changes. You're sleeping well enough. You're eating healthfully. You're getting exercise and the depression is still pretty notable. That's why we have medicine to be able to help in those circumstances. So I wouldn't jump to it as the very first thing but I wouldn't want to wait until more misery has been experienced than needs to be before trying it. That's where really being able to kind of understand a treatment plan and treatment options and talking that through with a clinician who's well versed is a good thing to do.

WEINSTEIN: And are teens treated for depression with the same medications as adults and how do medications affect the developing brain?

FRISTAD: The same medicines are used and the same medicines basically have been found to be efficacious. We really don't know the impact on developing brains because we haven't had long enough studies to really be able to follow kids. And most drug treatment trials are quite short. They are maybe 12 weeks. Maybe there's a six-month follow-up. Some of the studies have followed kids as long as 18 months. But we don't have what parents really want to know is, like 10 years later, what does it do to my child's brain and we don't have those answers.

WEINSTEIN: While I have you, what do you make of the research on nutrition and gut health in relation to depression?

FRISTAD: Sure. So we're beginning to learn about probiotics and the microbiome and gut health. We certainly don't have all the answers yet. We do have some nutritional data on treating kids. We at our site, we have finished an Omega 3 and psychotherapy trial and I can tell you that kids who get both a dose of Omega 3 Fatty Acids and psychotherapy do the best in terms of outcome. So I really do encourage people to eat a healthful balanced diet and it doesn't hurt to supplement with a daily vitamin mineral supplement, kind of your standard vitamin mineral supplement and to either make sure that you're eating a fair amount of those fatty fishes or taking an Omega 3 supplement. Those are some of the nutritional interventions that we have pretty clear data for now. We're learning more about the microbiome and probiotics.

WEINSTEIN: Yeah. It's all really exciting.

FRISTAD: But we don't know that any of that is bad for you so it certainly doesn't hurt to try that.

WEINSTEIN: I think that almost anyone can answer this and I would love to hear more than one view. This is a really hard thing that people go through. It takes a while to find the right medicine. It takes a while for therapy to work and sometimes things get worse. How do you maintain hope when nothing seems to be working to help your child? David?

DAVID: What one thing I can just add is that there are so many different treatment options that I think what people need to realize is that unless you are one of the lucky few who hits on the first treatment modality, therapy, medication, the right medication, the right therapist, whatever it is, that it's probably not going to work the first time. So I think people just, it's hard. It's really hard when things aren't working. But I would really encourage people that try something to give it a shot but try something different and realize that there are, there are a lot of other options out there.

SHEILA: I would agree that to maintain hope is really, really hard. You kind of ebb and flow. You have good points and then you sink down. So through the whole process that we've gone through, I just try to, it's your kid. You're going to do whatever it is that you can do to help them and I hold on to that knowing that nothing's going to stop me and we're going to find something and to the point that all I can share with people is when my world did fall apart and my son lost his battle, when I tried to heal, the one thing that kept coming in my mind was hope. That I had to teach people to find hope. So hope is important and you just got to hold on.

WEINSTEIN: Absolutely. OK. So we are pretty much at the end of our time. So let me give a quick reminder of when to take action. If there are suicidal thoughts or behaviors or there's non-suicidal self-injury like cutting, get in touch with a clinician immediately. If the circumstances warrant, go to the local hospital emergency room or call 911. If signs of depression last for two weeks or more or the mood or behavior interferes with functioning, contact a mental health clinician for an evaluation. There is really no reason to not take action when you have concerns.

So what do you do next? Let's send you out the survey right now. There's your link to the survey. And by all means, tell people about this training if you think it will be of help to them. Make an action plan to help your teen. You'll find a template on our website on the Teen Depression Training page. We welcome volunteers and we appreciate your contributions. I thank our panelists once again. I thank Valerie Cordero for her work in the background of this webinar and I thank you all for attending. Have a very pleasant evening.

[END]

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