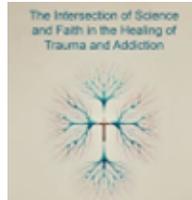
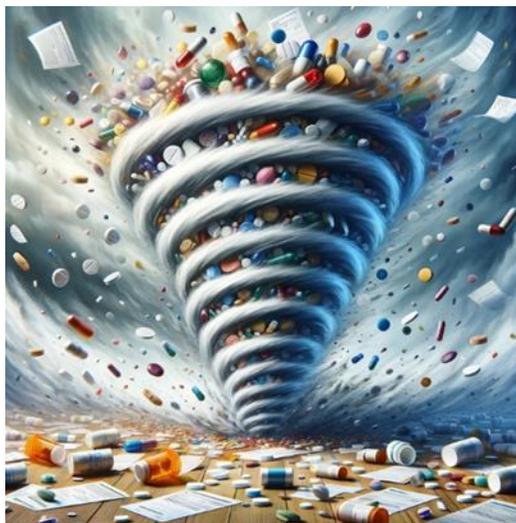


Pills Before Therapy: Rethinking Depression Treatment in Adolescents



Jeffrey E. Hansen, Ph.D.

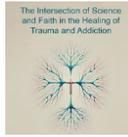


The growing epidemic of adolescent depression has been met with a disturbing trend: hasty diagnoses followed almost immediately by prescriptions for antidepressant medications. In doctor's offices and therapy clinics, teenagers barely finish recounting their woes before leaving with a pill bottle in hand. The rate of antidepressant dispensing to young people has skyrocketed, especially in recent years. For instance, one study found that the monthly rate of antidepressants dispensed to youth increased about 64% faster during the COVID-19 pandemic than before, with a staggering 130% faster rise among girls aged 12–17 (Archie, 2024).

Such statistics underscore an alarming reality: we are increasingly medicalizing normal teen sadness and reaching for medications as a first resort. This quick-fix, pill-first mentality ignores the complex roots of adolescent distress and poses serious risks to the very youth we aim to help.

Victimhood Culture: When Mental Illness Becomes a Status Symbol

In tandem with clinical trends, there has been a seismic cultural shift in how we view mental health. Today's youth grow up in a society that, in many ways, embraces victimhood. Through a neo-Marxist lens, social status is often determined by power dynamics: individuals are seen as either oppressors or



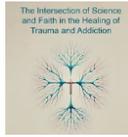
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oppressed. In this framework, being part of an “oppressed” group can confer a certain moral high ground. Mental illness labels have become status symbols in this cultural context, elevating those who suffer into a protected class of sorts. A teenager who is diagnosed with depression may receive sympathy, validation, and a sense of identity as someone who has been oppressed by illness or circumstance. This can create a perverse incentive to adopt pathology as persona – to wear one’s diagnosis like a badge of honor. Instead of fighting against depression, some teens might consciously or unconsciously embrace it as part of their identity, reinforced by social media echo chambers that valorize struggle. The cultural script whispers that being broken or ill grants you significance. This valorization of victimhood does a grave disservice to adolescents: it normalizes and even encourages the proliferation of mental health diagnoses, making it less likely that young people will question a label or seek to overcome it. In such an environment, a swift diagnosis and pill prescription not only provide a biochemical crutch but also social validation. The result is a dangerous positive feedback loop: the faster we diagnose and medicate, the more we reinforce the notion that to struggle is to belong.

The Storm and Stress of Adolescence: Natural Turbulence vs. Pathology

Every adult can remember the rollercoaster of emotions that define the teenage years. Adolescence is a time of existential and emotional turbulence – a period marked by intense heartbreak, profound angst, identity confusion, surging hormones, and a search for meaning. Feeling lost, alone, or inconsolably sad at times is completely natural for teenagers. First loves end in tears; friendships fracture; the pressure to define one’s future looms large. These experiences, as painful as they can be, are developmentally normal and even necessary. They teach resilience, empathy, and coping. However, in today’s diagnostic culture, the ordinary suffering of adolescence is increasingly pathologized. Instead of being reassured that “*this too shall pass*,” teens are often told they have a brain disorder or a “chemical imbalance” when they feel down. The line between normal angst and clinical depression has blurred. Certainly, some adolescents do suffer from severe, clinical depression that warrants treatment. But the pendulum has swung so far that we risk labeling every case of teenage heartbreak or academic stress as a mental disorder requiring medication. By medicalizing normal emotions, we send a dangerous message to young people that they are not equipped to handle life’s ups and downs without pharmacological aid. We short-circuit the natural process of learning to overcome challenges. A teenager who believes their sadness is a symptom of a chronic mental illness may start to ruminate on their victimhood and feel even more helpless – a self-fulfilling prophecy that deepens despair. It is essential to recognize that adolescence has always been a time of storm and stress; our task is to guide youth through the storm, not to numb them to it.



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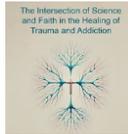


Many teens today are quickly classified as “depressed” when in fact they are experiencing the natural growing pains of youth. By treating these pains as pathologies, we risk robbing young people of the chance to grow. Every moment of sorrow in adolescence is also an opportunity: to develop grit, to discover inner strengths, and to gain wisdom. If we rush to slap a diagnostic label on a 15-year-old who is grieving a breakup or anxious about school, and then offer nothing but a prescription, we trivialize their experience. We imply that their sadness is something abnormal, a defect to be fixed chemically, rather than a valid emotional response to life’s challenges. This is not to romanticize suffering, but to contextualize it. Pain can be a teacher. A teen who works through heartbreak with supportive counseling, journaling, exercise, and time will likely emerge stronger and more emotionally skilled than one whose heartbreak is immediately numbed by Zoloft. The former learns that they can endure hardship and heal; the latter learns only that a pill can take emotional pain away – for now.

Consequences of Overprescribing Antidepressants to Youth

When we indiscriminately put adolescents on antidepressants as a knee-jerk reaction, the consequences can be dire. These medications are not benign “happy pills”; they come with significant side effects and long-term implications, especially for developing young brains and bodies. Some of the most concerning effects of overprescription include:

- **Emotional Blunting and Numbness:** Antidepressants, particularly SSRIs, often dull the intensity of emotions. While this blunting might mute the depths of despair, it also flattens the peaks of joy. Teens on SSRIs frequently report feeling like a zombie or a hollow shell, unable to cry, but also



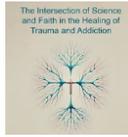
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unable to truly laugh or feel excited. Research indicates that about half of SSRI users experience a “psychic flatness”, a loss of the ability to experience positive feelings like pleasure and joy (psychiatrist.com, 2023).

In an attempt to shield young patients from pain, we may also be depriving them of vital human experiences – the full range of emotion needed for learning, relating, and developing an authentic sense of self.

- **Impaired Development of Coping Skills:** Adolescence is the training ground for adulthood. It’s when individuals typically learn how to cope with sadness, frustration, loneliness, and anger. If a pill numbs these emotions every time they arise, the teenager never learns to cope because they rarely face the full intensity of the feeling. Coping mechanisms – such as talking through problems, seeking support, engaging in hobbies, spiritual practice, or simply *enduring* a bad mood – require experiencing discomfort. By medicating away discomfort at the slightest sign of distress, we short-circuit the learning of resilience. Years later, in adulthood, these individuals can become ill-equipped to handle even mild stresses, having been deprived of the chance to build emotional muscles in their teen years. Moreover, some may come to believe that only a drug can make them feel “okay”, leading to a profound sense of dependency and lack of self-efficacy.
- **Dependency and Identity Tied to Medication:** Once an adolescent starts taking antidepressants, stopping can be challenging. They may become psychologically dependent on the medication, believing it’s the only thing keeping them functional. Biological dependence can occur as well; the body and brain adapt to the drug. When trying to come off SSRIs, patients often face withdrawal effects (euphemistically termed “discontinuation symptoms”) such as dizziness, insomnia, irritability, or a return of depression worse than before. This can scare a young person into staying on the drug indefinitely. Over time, a teenager can internalize the belief that “*I need this pill to be normal.*” The medication becomes a crutch, and their very identity might wrap around being someone with depression who needs antidepressants. This entrenched dependency undermines the fundamental goal of therapy – to empower the individual to heal and function autonomously. It’s a cruel irony that a tool meant to free someone from depression can, if overused, enslave them to a lifetime of medication.
- **Post-SSRI Sexual Dysfunction (PSSD):** Perhaps the most under-acknowledged and devastating consequence of adolescent antidepressant use is the risk of Post-SSRI Sexual Dysfunction. PSSD is a condition in which a patient’s sexual functioning does not return to normal after stopping the antidepressant – potentially persisting for years or even permanently. It includes symptoms like genital numbness, loss of libido, erectile dysfunction in males, vaginal dryness in females, anorgasmia (inability to orgasm), and even blunted romantic feelings. Imagine a teenager put on an SSRI at 16 for mood issues: by the time they are 18 or 20, they might discover that they cannot



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feel sexual pleasure or desire, even though they've long since quit the drug. For a young person just coming into their own sexuality and yearning for intimacy and connection, this outcome is nothing short of catastrophic. The medical community has been slow to recognize PSSD, but it is very real – European regulators have acknowledged it, and patient advocacy groups are raising alarms. As one researcher bluntly stated, Post-SSRI Sexual Dysfunction and related disorders may represent “iatrogenic epigenetic damage previously unseen in human history,” with individual consequences that are truly “catastrophic” (psdnetwork.org, 2025).

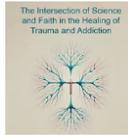
In other words, we may be witnessing medication-induced damage that fundamentally alters biology in ways we never anticipated. To inflict such a fate on adolescents – often without their informed consent or full understanding – is a grave ethical failing. PSSD doesn't just steal pleasure; it can steal future relationships, self-esteem, and the basic human experience of sexuality. **No teenager** – indeed, no person at all – should have to pay such a price for having sought help for depression.



The above consequences highlight a painful truth: overprescribing antidepressants can inadvertently harm young people in the very ways we're trying to help them. Emotional blunting robs them of feeling truly alive; dependency keeps them from becoming strong on their own; and PSSD can cast a long shadow over their adulthood. These effects are not rare one-in-a-million anomalies – emotional blunting is common, and while PSSD is considered rare, *“rare” side effects can still impact thousands when millions of teens are on these drugs.* The tragedy is compounded when we consider that many of these teens might have overcome their struggles without medication, through time and proper support, if only given the chance.

Overdiagnosis, Informed Consent, and Ignored Root Causes

Why has this overprescription phenomenon taken root? Part of the problem lies in overdiagnosis – the threshold for labeling a teen with “major depressive disorder” has lowered to the point that normal



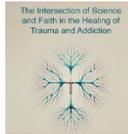
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sadness can qualify. Diagnostic criteria in psychiatry are subjective, and there's growing concern that we're turning typical behavior into illness. Well-meaning school counselors, pediatricians, and psychiatrists may be quick to apply a diagnostic label after a brief questionnaire or a 15-minute consult. Once the label is in place, the prescription pad often comes out. This rush to diagnose is fueled by several factors: pressure from overwhelmed parents desperate for a solution, practitioners constrained by brief appointment times (it's faster to write a prescription than to dig deep into psychosocial issues), and, unavoidably, the influence of pharmaceutical marketing that has for years promoted the narrative of "a pill for every ill." The result is diagnosis inflation – more and more teens being told they have a mental disorder.

Compounding this issue is a disturbing lack of informed consent in the treatment of young patients. In many cases, adolescents (and their parents) are not fully informed about what an antidepressant prescription entails. Crucial information is often glossed over: the potential side effects (weight gain, sleep problems, emotional numbing, sexual side effects), the typical duration of treatment (often many months or years, not just "try this for a week or two"), the possible difficulties in discontinuing the drug, and the fact that antidepressants are not guaranteed to be effective for mild or moderate depression. A teenager might think, *"I feel really sad, and the doctor gave me this pill, so it must be what I need"*, without understanding the trade-offs involved. Truly informed consent would mean the teen and their guardians are educated on all risks (like PSSD and dependency) and all alternatives (such as therapy, lifestyle changes, or simply monitoring symptoms for a while). Unfortunately, such comprehensive discussions are the exception, not the rule. The power dynamic between doctor and young patient can also impede informed consent – teens might not even know what questions to ask, and they often trust that whatever the doctor is recommending is safe. Thus, many adolescents start SSRIs without a clear sense of what they're getting into.

Equally concerning is the widespread failure to explore root causes of a teenager's depressive symptoms before resorting to medication. Depression is not a one-size-fits-all phenomenon with a single etiology. A teen's low mood might be stemming from **bullying at school, an identity crisis, family dysfunction, academic pressure, past trauma, social media influences, poor diet, lack of sleep, or a combination of many factors**. If we do not take the time to peel back these layers, we end up treating a symptom (sadness) rather than the cause. It's akin to turning off a fire alarm without bothering to check for a fire. Sadly, the current system frequently opts for the quick silencing of the alarm. A teenager comes in with tearfulness and withdrawal, and rather than asking *"What's been happening in your life?"* the system is primed to ask *"Which medication should we try?"* The underlying issues – perhaps a recent breakup, or feelings of inadequacy fueled by Instagram, or confusion about sexual orientation, or grief from a grandparent's death – may remain unaddressed. The young person is sent home with their emotional pain chemically blunted but no solutions for the problems that caused that pain. This is a travesty of care. Imagine a 14-year-old girl who is depressed because she's being bullied relentlessly online. If no one helps



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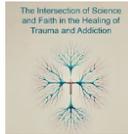
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her address the bullying, an SSRI might numb her enough to function, but inside, the true wound festers. We owe our youth more than this surface-level treatment. We owe them true healing, which comes from understanding and resolving the roots of their suffering.

A Holistic Path Forward: Therapy, Not Just Pills

If immediate medication is not the answer for every adolescent who feels depressed, then what is? The alternative path forward is a holistic, person-centered approach that seeks to heal rather than just medicate. This approach recognizes that adolescents are *resilient beings capable of growth and change*, especially when given proper support and tools. Key components of a more balanced strategy include psychotherapy, skills-building, and integrative mind-body-spirit techniques – many of which have proven efficacy in alleviating depression and anxiety. Before resorting to medication (or alongside a carefully monitored, minimal use of it), we should deploy approaches such as:

- **Cognitive Behavioral Therapy (CBT):** CBT is a well-established talk therapy that helps individuals identify and challenge negative thought patterns. For a depressed teen, CBT can be incredibly helpful – teaching them to catch the exaggerated gloom-and-doom thoughts (“*I’ll never have friends*”, “*I’m a total failure*”) and replace them with more balanced, realistic ones. Over time, CBT can reduce depressive symptoms and give adolescents a lasting skill: the ability to manage their own thoughts and emotions. Unlike a pill, which simply masks the feeling, CBT addresses the thinking traps that often underlie depression. Studies have shown CBT can be as effective as medication for mild to moderate depression, with the benefit that its effects *last* because it empowers the individual.
- **Dialectical Behavior Therapy (DBT):** Originally developed for intense emotional disorders, DBT equips young people with practical tools for emotion regulation, distress tolerance, and interpersonal effectiveness. Adolescents prone to mood swings, self-harm urges, or suicidal thoughts can particularly benefit. DBT teaches skills like mindful breathing to survive a crisis moment, or how to communicate feelings without alienating others. By learning DBT’s core skills (Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness), teens gain a sense of mastery over their internal storms. This therapy literally builds the neural and behavioral pathways for coping – something no medication can do for them.
- **Internal Family Systems (IFS) Therapy:** Part of a broader integrative model (such as my *NeuroFaith* framework), IFS helps individuals work with their inner emotional parts. An adolescent might say, “Part of me is so angry, part of me is just sad and wants to hide.” IFS externalizes these feelings into “parts” (like an inner angry part, a wounded child part, a perfectionist part, etc.) and helps the person develop a compassionate relationship with each part. This can be profoundly healing for teens dealing with internal conflicts or trauma. Instead of viewing themselves as

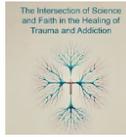


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“broken,” they learn that all their feelings have a place and purpose. IFS is a powerful tool for self-discovery and healing that treats the psyche as a family of sub-personalities, all deserving understanding. It can unburden traumas and negative beliefs that fuel depression, leading to deep and lasting emotional change.

- **HeartMath and Biofeedback:** HeartMath techniques use biofeedback technology and breathing exercises to help individuals synchronize their heart rate variability and achieve a state of calm and focused coherence. For anxious or depressed teens, seeing a real-time display of their physiology and learning that they can influence it (through breathing, positive imagery, or recalling feelings of gratitude) is incredibly empowering. It turns abstract advice (“just relax”) into a concrete skill (“here’s how to calm your heartbeat and feel centered”). Regular practice can improve stress resilience, sleep, and mood. It’s a holistic method that directly targets the stress response, teaching youths that they have the ability to self-regulate their nervous system.
- **Polyvagal-Informed Therapy:** Stemming from Dr. Stephen Porges’ Polyvagal Theory, this approach educates individuals about their autonomic nervous system – how our bodies toggle between states of safety (social engagement), danger (fight/flight), and life-threat (shutdown). Therapists trained in this approach help teens understand bodily reactions to stress (like why their heart races and they feel like running away during a panic attack, or why they feel numb and detached when overwhelmed). Through exercises like deep breathing, humming, cold water face dips, or therapeutic movement, adolescents learn to engage the vagus nerve and shift into a calmer state. They also learn how cues from the environment or relationships affect them, and how to create conditions of safety for themselves. By learning to navigate their own biology, teens can reduce anxiety and lift mood in ways that are natural and self-directed. And finally, the teen is help to re-narrate the negative story into a more realistic and positive one.
- **Spiritual Integration and Faith-Based Coping:** For many, *spirituality is a wellspring of resilience*. Integrating a teen’s spiritual or religious beliefs into therapy can provide a profound sense of meaning and hope. Whether through prayer, meditation, community service, or reflection on one’s purpose, spiritual practices can anchor a young person amidst chaos. The user’s NeuroFaith model, for example, explicitly combines neuroscience with faith traditions, recognizing that humans are not just biological machines but also seekers of meaning. A depressed adolescent can often benefit from exploring questions like, “*Why am I here?*”, “*What can suffering teach me?*”, or “*Is there a bigger plan for me?*” in a supportive setting. Such exploration can transform pain into growth. Even for those not inclined to formal religion, a sense of connection to something larger – nature, humanity, the universe – can instill hope. The goal is to tap into sources of strength beyond the ego: compassion, forgiveness, gratitude, and purpose. These are age-old antidepressants with no side effects. Most important, this along with Polyvagal-informed



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Therapy, helps the teen to address core negative beliefs about self (e.g., “I am not worthy, I am not valuable, I am not lovable”) that are always produced by trauma and, unless addressed, forever taint and even destroy the teen’s sense of self.

A hopeful depiction of healing and personal growth, symbolizing the holistic therapies that empower adolescents. Importantly, these holistic approaches are not mutually exclusive with medical intervention. There may be cases of adolescent depression so severe that medication is warranted. But even in those cases, therapy and holistic care should ride alongside the medication, addressing dimensions of the person that pills cannot touch. By prioritizing therapies like CBT and DBT, and integrative methods like IFS, HeartMath, and polyvagal exercises, we equip young people with life-long skills and insights. We treat the *whole person* – mind, body, and spirit – rather than just numbing the symptoms. This comprehensive care model honors the fact that depression in a teen is often a cry for help, not merely from their brain chemistry, but from their whole being and their environment. We need to answer that cry with human connection, understanding, and empowerment, not just a prescription.

Conclusion: Reclaiming Youth Mental Health – A Call for Urgent Reform

It is time for an urgent course-correction in how we address adolescent depression. The current paradigm of “diagnose fast and medicate faster” is failing our youth. We are witnessing an unintended experiment play out on a generation, and the results are harrowing: too many teens dependent on antidepressants, numb to life, and bereft of coping skills, some even with permanent sexual dysfunctions before they’re out of college. This is not youth mental health care; it is a betrayal of youth. We must reclaim the treatment of adolescent depression from the quicksand of overdiagnosis and overprescription.

Reform starts with a cultural shift in expectations. We, as a society, must stop glorifying victimhood and instead celebrate resilience and recovery. Being a survivor or fighter should carry more cachet than being a victim. Adolescents should be taught that suffering is not a permanent identity, not a badge to showcase, but a challenge to overcome. In clinical practice, reforms should mandate comprehensive informed consent for any psychiatric medication given to minors – including a frank discussion of side effects like emotional blunting and PSSD. Doctors should be encouraged (or required) to exhaust psychotherapy options and investigate environmental factors before reaching for the prescription pad in cases of mild-to-moderate depression. Schools and communities, too, have a role: promoting counseling resources, peer support groups, mentorship programs, and psychoeducation about emotions and coping from early ages.

Policymakers and professional boards can help by updating guidelines to curb reckless prescribing. For example, requiring a minimum number of therapy sessions or a psychological evaluation prior to medication for adolescent depression could slow the assembly line of SSRI scripts. Insurance companies must also come on board, recognizing that paying for therapy and holistic treatments now will save costs



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on medications and hospitalizations later. And importantly, pharmaceutical companies and the FDA should ensure that warnings about risks like PSSD are prominently disclosed whenever SSRIs are prescribed to young people.

Ultimately, what we seek is a world where every teenager’s cry for help is met with compassion and wisdom, not just a chemical solution. We owe it to our children to give them the safest and most genuine healing possible. The angst of adolescence is not a disease to be eradicated, but a journey to be guided. By reforming our approaches now – by privileging therapy, informed consent, and holistic care – we can prevent countless cases of blunted lives, thwarted potential, and prolonged suffering. We can instead cultivate a generation of young adults who emerged from their dark times not dependent on a drug, but equipped with self-knowledge, resilience, and hope. The time for this change is now. The hearts and futures of our youth depend on it.

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ChatGPT disclaimer: This piece was created by consolidating my prior writings, with assistance from AI to help articulate and expand on key ideas and perspectives I’ve previously shared.