

MEDICAL OFFICERS OF SCHOOLS ASSOCIATION

GUIDELINE ON DEPRESSION IN ADOLESCENTS

Introduction

It is well known that adolescents are prone to mercurial mood swings, particularly early on.

Causes for this include:-

- a) Self consciousness due to increasing self awareness
- b) Hormonal influences
- c) Self examination of emotions
- d) Experiments in developing an identity

The term “depression” may be used as a blanket term to cover those normal mood swings- a “catch-all” term that has “street-cred”.

An accurate understanding of the adolescent’s use of the term is crucial to the diagnosis and management.

The prognosis for depression in childhood or in adolescence is not very good. While the majority will recover from the depressive episode within 12 months, major depression is a recurrent condition and it is likely to recur in adulthood.

Epidemiology

It is recognised depression is very difficult to diagnose reliably. However it is not a rare condition. In pre-adolescent children the frequency of depression is 0.5 to 2.5%. In adolescents it is between 2 and 8%.

Depression is equally common in pre-adolescent boys and girls, but more common in adolescent girls than boys. The reason for this is unclear.

Diagnosis

The diagnosis is made on the history primarily. As well as from the patient the history may be obtained from sources such as teaching staff, matrons, peers and family.

Confidentiality could well be an issue here. If the patient’s agreement to talk with others is not forthcoming consideration will need to be given as to whether such contacts are in the patient’s best interests.

It is highly likely there will be a reaction to any such contact and this needs to be anticipated. For example, it may be appropriate for a meeting with the adolescent’s parents to be arranged with or without the teacher most closely involved and with or without the subject’s informed consent.

A cardinal question is:-

“Is the patient distressed or depressed?”

Distress is essentially a frustration with :-
the current mood
the current situation
the current relationships

Resulting negative feelings from distress act as a catalyst for the patient to effect change.

Distressed patients have “active” symptoms:-
Acting out behaviour
Anger/rages
Active mood of unhappiness

The GP’s role in the “distressed” patient is to monitor the patient and to help the patient effect the changes necessary.

Depression Symptoms

- Depressed or irritable moods
- Decreased interest in pleasures
- Weight changes
- Sleep changes
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness
- Feelings of guilt
- Reduced concentrating/decision making ability
- Repeated suicidal ideation or plans

Five or more of these symptoms must be present for a minimum of two weeks.

Depression is more common in those:-

- who are female
- who have a previous history
- who have a family history

Depression may be associated with other disorders:-

- Anorexia nervosa
- Bulimia nervosa
- Overeating
- Drug dependencies, alcohol abuse
- Learning difficulties
- Gender confusion

Chronic illness, e.g. glandular fever
Social/family problems

Suicide

Teenage suicide is not a rare event and it is on the increase, particularly in males. In 1997 in the UK two people between 15 and 24 died each day through suicide, and over 80% were male.

Parasuicide too is common. A conservative estimate is there are 19,000 cases of parasuicide in the UK each year in the age group 10 to 19 years.

There is no validated method for identifying people at risk. It probably comes down to a clinical judgement based on risk factors and the practitioner's experience. It is important to remember adolescents tend to deal with feelings impulsively.

Where suicidal ideation is suspected these questions may help in evaluating risk:-

- Have you thought of harming yourself?
- How strong is the urge to harm yourself?
- Have you a plan to harm yourself?
- What preparations have you made to harm yourself?
- Suppose you harmed yourself and died, what do you hope your family/your mother/your Father/your brother/your sister would think/do/feel?
- Suppose you harmed yourself but didn't die, what do you hope your family/your mother/your father/your brother/your sister would think/do/feel?
- Do you want to escape from something or some situation?
- Do you want to punish somebody by harming yourself?

Management

There are several theories as to the cause of depression:-

- Psychoanalytic theories - early separation/bereavement and critical parenting
- Behavioural theories - lack of reinforcement or poor self-reinforcement skills
- Cognitive theories - negative interpretation of ambiguous events
- Systemic theories - problematic family relationships
- Biological theories - genetic factors: dysregulation of specific neurotransmitter systems: endocrine dysfunction: immune system dysregulation: disruption of the sleep/waking cycle: seasonal biological changes

In view of the complexity of the aetiology in each case, it is advocated each patient has a thorough assessment. Available evidence suggests that management based on the principles of cognitive behavioural therapy, family systems therapy and social learning theory is the treatment of choice.

Anti-depressant medication is often of no value in adolescents and it is uncertain as to the long-term effects of such treatment on the developing brain. However, that is not to say there is no place for such treatment in individual cases.

It is strongly recommended therefore that adolescents with suspected depression should be referred to a consultant in adolescent psychiatry. Pending this assessment, the patient should be monitored closely, that in itself being therapy, because "this sense of needing someone to know about disturbed feelings is one that is commonly felt by adolescents". A responsive adult may well be able to contain their anxieties.

In cases where there is strong suicidal ideation or para suicide, urgent referral is indicated for risk assessment.

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