Adolescent Depression: Signs, Symptoms, and Treatment

Joseph W. Dickson, MA, LPC, NCC

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- Depression the Illness
- Prevalence and Data
- Adolescent Suicide-Behavioral/Emotional/ Social Factors
- Treatment: Therapy, Medications, Hospitalization, etc.
- Helping Teens
- Mental Health Screening

Major Depressive Episode

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
- *Note:* Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.
- depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful) Note: In children and adolescents, can be irritable mood.
- markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
- significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: in children, consider failure to make expected weight gains.
- insomnia or hypersomnia nearly every day
- psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness of being slowed down)
- fatigue or loss of energy nearly every day
- feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- B. The symptoms do not meet criteria for a Mixed Episode.
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Source: DSM-IV TR, American Psychiatric Association

Depression the Illness

- DSM-IV Types of Depression
  - Major Depressive Disorder
  - Single Episode, Recurrent
  - Mild, Moderate, Severe
  - With/Without Psychosis
  - Postpartum Onset, Atypical Features, Catatonic Features, Melancholic Features
  - Dysthymic Disorder
  - Early/Late Onset
  - Atypical Features
  - Depressive Disorder NOS

American Psychiatric Association, 2000

Depression the Illness

- Major Depressive Disorder
- Lifetime Risk: 10 to 25% for women and 5-12% for men.
- 1.5-3x more common among first degree biological relatives of persons with depression.
- 5-10% of people with Major Depression subsequently develop a Manic Episode
- 2x as likely in adolescent and adult females than males. Rates are equal for prepubescent males and females.
- Differential Diagnosis

American Psychiatric Association, 2000

Depression the Illness

- <u>Dysthymic Disorder</u>
- Lifetime prevalence of about 6%
- More common among first degree biological relatives
- Adult and adolescent women 2-3x more likely to develop the disorder then men.
- Occurs equally in both sexes for children
- Differential Diagnosis
- <u>Depressive Disorder NOS</u>
- PMDD
- Differential Diagnosis

American Psychiatric Association, 2000

Potential Differences in Teen and Adult Depression Presentation

- Teens often appear as oppositional and/or defiant.
- Easily angered, irritable, and reactive.
- Externalizing vs. Internalizing
- Negative self-talk and misperceptions of self as bad person or flawed.
- More likely to attempt suicide impulsively
- Girls attempt suicide more but boys are more successful due to use of more violent means

The Impact of Mental Illness

- Twenty-one percent of US children ages 9 to 17 have a diagnosable mental or addictive disorder that causes at least minimal impairment
- In any given year, only 20% of children with mental disorders are identified and receive mental health services
- 10% of US children and adolescents suffer from a <u>serious</u> mental disorder that causes significant functional impairments at home, at school, and with peers
- 50% of children with serious emotional/behavioral disorders drop out of high school, compared to 30% of students with other disabilities (US Dept. of Education, 2001).

- Mental Health: A Report of the Surgeon General (1999)
- Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda (2000)
- Kessler et al., 2005

Suicide in High School Age Youth

- Suicide is the 3rd leading cause of death for 15-19 year-olds
- Almost as many teens die by suicide as those who die from all natural causes combined
- 17% of US high school students report serious thoughts of killing themselves each year
- 13% of US high school students report making a suicide plan
- 9% of US high school students report attempting suicide
- 3% of US high school students report having made a suicide attempt that required medical attention

Anderson 2004; YRBS 2005;
U.S. Census 2003

Linking Mental Illness with Suicide

- 90% of teens who die by suicide suffer from a diagnosable mental illness at their time of death
- Psychiatric symptoms developed more than a year prior to death in 63% of completed suicides
- In only 4% of cases, psychiatric symptoms developed within the 3 months immediately prior to the suicide
- Suicide is not the unpredictable event we once thought it was

Shaffer et al. 1996

Mental Health and Academic Achievement

- 50% of children with serious emotional/behavioral disorders drop out of high school, compared to 30% of students with other disabilities (US Dept. of Education, 2001).
- Students with mental illness have the highest drop out rate of any disability group (U.S. Dept. of Education, 2001).
- Over half of the adolescents in the United States who fail to complete their secondary education have a diagnosable psychiatric disorder (Stoep et al., 2003).

Behavioral/Social/Emotional

- Heavy drug or alcohol use
- Change in academic performance
- Recent loss or impending loss of love object
- Pregnancy
- Homosexuality (lack of social support)
- Running away
- Prior suicide attempts or family history of suicide
- Intense anger

Behavioral/Social/Emotional

- Preoccupation with violent death of another person
- Impulsivity
- Learning disability
- Ineffective coping
- Lack of resources and feelings of alienation
- Hopelessness, helplessness

Behavioral/Social/Emotional

- Risk-taking behaviors
- Loss of support system
- Recent move or change in school
- Family members leave home or change in financial status, divorce and conflict
- Feeling anonymous and unimportant
- Peer group activity associated with death

Behavioral/Social/Emotional

- Giving away possessions
- Persistently talking about death and/or suicide
- Planning what will be left of possessions and to whom
- Talking to friends about not seeing them again, or “if anything happens…”
- Abuse and/or neglect from caregivers

Family Factors Associated with Resilience for Adolescents

- Family togetherness
- Help among family members
- Ability to resolve conflict in family
- Positive communication
- Clear leadership in the family
- Sharing of emotions
- Parental satisfaction with school performance
- Positive sibling relationships
- Sibling support

Carbonell et al, 2001 The Prevention Researcher, Vol 8, #4

Treatment of Depression

- Individual, Family, and Group Therapy
- Cognitive/Behavioral Therapy (CBT)
- Situation-Thoughts/Beliefs-Emotion
- Education
- Relapse education and prevention
- Medication Evaluation/Administration
- Hospitalization for imminent dangerousness to self or others. Crisis stabilization and treatment, short term.

Pharmacological Treatment-SSRIs

- Selective Serotonin Reuptake Inhibitors (SSRI)

  - Prozac, Paxil, Luvox, Celexa, Zoloft, Lexapro, Cymbalta, etc.

  Used in treatment of depressive disorders, OCD (esp. Luvox), Anxiety Disorders, Panic Disorder, PTSD, Phobias, Bulimia.

  Can be used as adjunct to pharmacotherapy for schizophrenia and psychotic disorders.

** Contra-indicated for patients w/ Bi-polar illness as SSRIs may potentiate manic symptoms.

  - Generally takes 2 to 4 weeks to become effective.

SSRI Side Effects

- Drowsiness, lethargy
- Difficulty sleeping, nervousness
- Headache
- Nausea, heartburn
- Muscle tremors, twitching
- Sexual dysfunction
- Blurred vision, Dry mouth, Constipation, Nightmares
- Appetite loss

** Side Effects generally abate within a month

Tricyclics and Novel Antidepressants

- Wellbutrin-Norepinephrine/Dopamine Reuptake Inhibitor (NDRI)
- Effexor-Selective Serotonin/Norepinephrine Reuptake Inhibitor (SNRI)
- Serzone/Desyrel-Serotonin-2 Agonist/Reuptake Inhibitor (SARI)
- Others-Elavil, Remeron, MAOIs

Pharmacotherapy

- Antidepressants and Antipsychotics
- Antidepressants and Anxiolytics
- Mood Stabilizers and Antidepressants
- Medication resistant depression
- Comorbid disorders
- Titration and effective dosages
- Black box warnings for Children and Adolescents

Medication Precautions

- Medications are only indicated for disorders that truly exist. Many factors such as substance abuse, medical problems, and environmental problems can mimic a mental disorder. Substance abuse in particular can look like a mental illness. Substance use can (particularly cocaine and stimulants) produce psychotic Sx that usually abate without the substance. Additionally, the opponent process of many substances may produce compensatory depression or manic-like Sx. Medications should NEVER be discontinued without Dr. supervision

Medication Precautions

- Although Family Physicians can and do prescribe psychotropic medications, it may be preferable to see a Psychiatrist as they specialize in the treatment of mental disorders and medications for these disorders. Of course, medications should never be administered to persons other than for whom the prescription was written. If a child or adolescent appears to have severe or worsening side effects from a medication, consult a nurse or Dr. and inform the family of your concerns. Be alert to any potential medication allergies

Talking to Adolescents about Depression

- The idea of stigma
- Sadness often looks like anger
- No Labels, non-judgmental
- Normalize feelings as the teen may feel he/she is the only one feeling this way.
- Teens tend to talk less about how they really feel for fear that peers will view them as “crazy”.
- Self-Disclosure (use with caution)
- Establishing rapport, safe environments, trust.
- “Adolescence in essence is all about trust”.

Helping Teens

- Identification of Problems
- Screening Programs, Community collaboration, SAPs, referrals, communication, school monitoring and check-ins
- Involving parents as experts on their child to gain cooperation and input. Parents often refuse treatment if they feel they will lose control or that their beliefs/feelings are discounted.
- No “Drive thru window” treatment. It is more than likely that issues within the family system need to be addressed as well.

Helping Teens

- DSS referrals in cases where the child is clearly ill and the parents refuse to get treatment.
- 1 Gallon of Gas – address only the most severe problems first. Self-mutilation vs. wearing a Marilyn Manson T-shirt.
- No instant problem solving. Help the teen to work through the problems not tell them how to do it.
- Listen.
- As much as it pains us adults, familiarize yourself with adolescent culture. Understanding this culture is crucial to establishing rapport and trust.

Helping Teens

- Always take suicidal statements seriously, even if they are said in a joking manner. Teens will often "test the waters" to gauge reactions from adults.
- Share your concerns with school personnel that can get help for the teen; Guidance Counselors, administrators, etc.
- Visit websites about teen depression and other teen issues.
- Take an interest in the Teen's life. It is amazing what a difference just having someone listen to you can make.

Helping Teens

- Try looking at disruptive, oppositional, and troublesome kids in a different light. Behavior is usually reflective of what's going on inside of us.
- Don't be afraid to talk about your concerns for fear a parent or student may get angry. Angry is better than dead any day.

Making Mental Illness a Priority

- **PKU: affects less than 1% of children**
- **Lead Poisoning: affects 2% of children**
- **Scoliosis: affects less than 1% of children**
- **Hearing Problems: 1-2% of children have moderate to severe hearing loss**
- **Vision Problems: affects 15% of children**
- **Our children are routinely screened for these problems but not for mental illness.**
- **21% of 9 to 17 year olds have a diagnosable mental health or substance abuse disorder in the U.S.**

- American Academy of Family Physicians, 1999; CDC, 2003;
- National Center for Health Statistics,
- U.S. Department of Health and Human Services, 2000
- Windeler J. & Kobberling J., 1987

Screening for Mental Illness

- Teen Screen
- School based mental health screening.
- Confidential. Requires parent and teen consent.
- If test results indicate possible mental illness or risk of harm to self or others, teens are interviewed on the spot for further evaluation. They may then be referred for additional treatment and follow-up.

Reasons to Screen for Mental Illness

- 74% of teens who were currently thinking about suicide were not known to school personnel
- 50% of teens who made a prior suicide attempt were not known to school personnel
- 69% of students who met criteria for depression were not known to school personnel

Shaffer and Craft, 1999

Reasons to Screen for Mental Illness

- Almost two-thirds of suicidal-teenagers were not known to school professionals
- One-half of suicidal teens were not known to either school or mental health professionals
- One-third of highest-risk teens were not known to either school or mental health professionals
- Only 1.6% of highest-risk teens were known to a mental health professional

Effectiveness of Screening

- 26% of teens who screen positive for suicidality in high school will make a later attempt or meet criteria for a mood disorder as young adults
- High school screening correctly identifies 2/3 of those who make a later suicide attempt or experience MDD as young adults