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Depression in Adolescents

Emotional ups and downs are part of most people's adolescent years, and form part of the normal range of experience. However, for some young people depression presents a serious challenge and a threat to their overall well-being, personal and social development, and academic attainment. Depression may be a primary reason for young people presenting to services, or presenting with other problems. Also many depressed adolescents do not present to services and remain undetected and untreated. Thus, the detection, assessment and treatment of depression in adolescence are crucially important for practitioners in services to young people. The most comprehensive guidance for the detection, assessment and treatment of depression in adolescence is provided by NICE (September 2005). All those who are likely to require information on these aspects of depression should consult this document. The short overview guide is available at: http://guidance.nice.org.uk/CG28/quickrefguide/pdf/English

Depression is a common psychological disorder that affects all ages. 1-3% of pre-adolescent children may suffer depression but with the onset of puberty the vulnerability to, and rates of, depression increase substantially, comparable to young adults. Thus by mid to late adolescence the prevalence of depression is typically found to be in the range of 3-8%. However, much depends on definition. When lower thresholds are used and mixed anxiety-depressed states included, the rate can be substantially higher. Studies of adults with depression show that many individuals experience their first symptoms during their adolescence. There is little gender variation in childhood but with adolescents the adult pattern of a female male ratio of 2:1 emerges. Explanations for this variation reside in biological, psychological and social factors. There is some evidence for gender differences in symptoms with girls being more prone to crying and poor body image and boys more prone to irritability.

Diagnosing Depression

Various combinations of these symptoms can wax and wane with varying degrees of intensity. However, the actual diagnosis of specific depressive disorders is complex and at times controversial. This is because depression is a heterogeneous condition that can vary in regard to the pattern and stability of symptoms, severity (mild - moderate - severe), chronicity and frequency (relapse rate), and can be co-morbid with other difficulties such as eating disorders or personality difficulties. While some depressions are related to distinct disorders, such as bipolar disorder, other depressions can be seen as dimensional variations of mood variations, linked to interactions between temperament, family dynamics, and difficulties with school, peers or other life difficulties.

Using the American system for diagnosis of major depression the adolescent would have clear evidence of loss of motivation and/or anhedonia, together with at least four other symptoms and these would be mostly constantly present for two weeks or longer. However, people can also experience what are called sub-clinical or sub-syndromal conditions meaning there are either not enough symptoms, the symptoms are not intense enough or long lasting enough to warrant a specific diagnosis. If the symptoms are milder than for major depression but have lasted a year or more then the clinician may consider the possibility of a condition called dysthymia.

The European classification system developed by the World Health Organisation distinguishes between mild, moderate and severe depression and focus on the degree of the presence or absence of somatic symptoms; and for severe depression, psychotic symptoms.

Nature of depression

Key Symptoms

Depression affects us in many different ways and symptoms are spread over different aspects of functioning:
Motivation: Adolescents can experience apathy, loss of energy and interest with things seeming pointless.
Emotional: The capacity for different types of positive emotions is reduced, and with moderate to severe depression the adolescent may become anhedonic - meaning they lack, or have a reduce capacity to experience fun or pleasure; they may talk of 'feeling empty'. In contrast, negative feelings can increase and there can be heightened experiences of anger, irritability resentment, anxiety, shame, envy and guilt.
Cognitive: Cognitive functioning may deteriorate and the depressed adolescent may have problems maintaining attention and concentration. Memory can also be affected. In regard to the contents and the focus of their thoughts these can become focused on negative ideas about the self (feeling inferior to others and low self-esteem, the world (as a harsh and unpleasant place) and the future (not much will change). Increases in hiding way and depressive rumination can also increase and act to maintain the negative focus.
Behavioural: Depressed adolescents may stop engaging in behaviours that had been enjoyable or pleasurable in the past. They may withdraw from social activities, stop going out or meeting with friends or seeking help from others. Alternatively, they may become more demanding and cling to others - desperate for reassurance. In severer forms of the condition they may suffer from psychomotor agitation and restless, or retardation
Somatic: Depressed adolescents commonly experience problems in sleeping such as difficulty falling asleep, waking up early or sleeping too lightly. They may lose their appetite (with weight loss) and interest in sex (or may become preoccupied with it). Feelings of fatigue and exhaustion are commonly associated with depression and at times people can feel that it is the fatigue that is making them depressed.
Physiological: There are many physiological changes especially in stress hormones (e.g., cortisol) and important neurotransmitters such as serotonin and noradrenalin. Depression is also associated with changes in activity in various brain areas such as the frontal cortex and amygdala.

Complications

Adolescent depression comes with a number risks for other problems that can have long-term consequences for academic achievements and confidence that will affect subsequent careers and employment. Another common problem is with interpersonal relationships that can be both cause and consequence of depression. Depressed adolescents can find it hard to develop the supportive and intimate friendships that are important to emotion regulation, the development of self-esteem and social confidence. Pre-existent shyness and/or social anxiety is a known vulnerability for later depression and is often co-morbid with it. As a result of their social hesitancy, withdrawal, a self-focused cognitive style or irritability they may be excluded or shunned. Depression is also commonly associated with bullying – some may even identify with and engage in bullying themselves.

Depression, and the social behaviours associated with it, can be early signs of more serious difficulties to come, such as in rare cases a psychosis. When fatigue is a major symptom there is the possibility of undiagnosed physical illness (e.g., hypothyroidism or early onset diabetes). Adolescent depressions can lead on to, or be associated with, impulse control difficulties and eating disorders. Low mood and anxious adolescents can feel isolated and alienated and drift towards drug or alcohol cultures that might provide some ways to control mood and give a sense of belonging or sense of respite. The depressed adolescent might become more reckless, taking risks that put them in danger. It is not uncommon to find the adolescent who has a problem with drugs to have difficulties with self-esteem and mood. Depressed adolescents can engage in risky sexual behaviours. A recent report by the American Psychological Society suggests that the cultural sexualisation of girls contributes to low self-esteem and depression in girls.

A third major complication is of depression is linked to various forms of self-harming. Self-harm can be self-cutting or self-burning as a way to control turbulent feelings. Depressed adolescents can be drawn to internet 'chat rooms' when such behaviours are discussed. These ways of dealing with depression and turbulent feelings can become forms of avoidance thus making it difficult for the adolescent to learn how to cope with the complexities of life as they emerge into adulthood.

Linked to self-harm is suicide. Depression greatly increases the risk of suicide possibly by as much as causing a 30 fold increase in adolescence. While suicidal thoughts can be normal experiences of adolescents, there are some key additional signs that should be noted. Family history of mental disorder, drug and alcohol abuse, impulsive behaviour, social isolation, feelings of being trapped, bullying, dramatic mood shifts, low self-esteem, risk taking or impulsive behaviour, problems expressing or sharing feelings, sense of dread and/or hopelessness and lack of purpose, - can all be signs linked to suicide. In addition, threatening to kill oneself, talking about wanting to kill oneself and thinking about ways of how to do it are key signs to be aware of.

Causes of depression

Because depression is a heterogeneous condition, which has been called 'a final common pathway' for a range of interacting factors, there are no single causes, Individual variations are linked to different combinations of different factors. Causes are usually linked to early vulnerability, current vulnerability and provoking agents or life events. Early vulnerability includes a range of factors such as genetic and temperamental factors. However, evidence also shows that in order for a genetic risk to give rise to depressive disorders there is often an environmental contribution in the form of early childhood stress. Environments can affect how genes are expressed. Indeed, we now know that children from insecure attachment relationships are vulnerable to depression and other disorders. The exact stresses that increase vulnerability are still subject to research but the obvious candidates are physical and sexual abuse and neglect. Verbal abuse in the form of name calling, criticising and shaming children and adolescents have been found to be major factors for depression vulnerability. Living in stressful and domestically verbally abusive and violent households are also risk factors. Outside of the dynamics of the family peer group bullying is significantly related to adolescent vulnerability. Adolescence can be a time when peers are testing and shifting alliances.

Adolescence is a time of major changes in: Hormone profiles including major changes in the organisation of the brain; social needs and interest (including emerging sexuality); and self-identities. New competencies and concerns to build a self-identity emerge and bring with them their own adaptive challenges. A key process that enables adolescents to work through these life changes is their general liking and acceptance of self. There is now evidence that children, who are self-critical at the age of 12, are vulnerable to later psychological difficulties. Indeed, self-criticism and self-disliking are regarded as key vulnerability factors that people can take through from childhood into adolescence and adulthood.

Some studies suggest that vulnerable adolescents have a relatively negative cognitive style. There is a tendency to make negative, often self-referent attributions for negative events; they may have a range of unhelpful attitudes about life and how to prosper in it (e.g. people will only like me if I am ….); they can have a ruminative style, finding it difficult to refocus their thinking or share feelings when effected by setbacks or disappointments.

Another key vulnerability factor is shame. Shame has two main domains. External shame relates to the feelings we have when we think people are looking down on us. We believe that in the minds of others we are seen as undesirable and rejectable or contemptible. The fear of what others think of the self, with a need to feel accepted and have a sense of belonging is intensified during adolescent years. Hence external shame, concerns with reputation and stigma, are key to self-identity. Internal shame relates to feelings and thoughts we have about ourselves. Having a sense of shame for the self is strongly linked depression. A number of studies have shown that shame is a key process that mediates between stressful life-events and depression. In other words if children can come through traumatic events without having a sense of shame and can still feel positive about themselves, they are less vulnerable to depression than those who cannot. It is probable that it is the way early environments shape the child's and adolescents experience and expectations of others, and their own self-feelings and emotion regulation strategies that can act as bridges into depression.

Detection and Assessment

Changes in appearance and mood, social withdrawal, fatigue, poor concentration, high levels of shyness or anxiety, various somatic complaints or changes in academic difficulties may raise suspicions and indicate a need for more detailed assessment. For non-clinicians these observations should prompt concerns and discussion with the adolescent and/or their parents. The practitioner will express gentle, caring concern with inquiry into the adolescents feelings and possible concerns and problems. For example a practitioner may say "I note that you might be having difficulties with… and I was wondering how you are feeling about things? There should be nothing heavy handed about this and the focus should be on gentle concern to enable the adolescent to feel safe to talk. From here a first intervention might be "I wonder if it might be helpful for you to have a chat with our school nurse? For there or directly the practitioner might recommend assessment by their GP.

As the NICE guidelines highlight, formal diagnosis of depression will be made by trained clinicians. Formal assessments will explore possible physical causes, and psychosocial vulnerability factors, triggering factors, maintenance factors that help indicate possible interventions. Assessment will also explore possible self-harm that will include suicidal thoughts, engaging in self-harming behaviour (e.g., cutting) or engaging in behaviour that puts the adolescent at risk (e.g., using drugs or forms of reckless behaviour). In addition to clinical assessment, self-report measures are available such as the Childhood Depression Inventory as developed by Kovacs.

Full assessment should follow a biopsychosocial format exploring Psychological factors, social and life events and somatic/biological presentations.

Individual and group delivered therapies can vary but are often focused and targeted to address specific problems

1. *Exercise and Diet:* NICE suggest that specific exercise regimes can be helpful for some depressions. In addition attention to diet and sleep management is important.
2. *Relaxing training and anxiety management.* Various forms of anxiety, especially social anxiety, can be co-morbid with depression. There are a variety interventions for such anxieties. In regard to coping with the feelings of anxiety procedures from muscle relaxation through to the use of various imagery tasks that help anxious adolescents gain some control over their anxiety can be helpful. In addition various activities can be helpful for anxiety regulation. The main thing is for the adolescent to understand the nature of anxiety, how it works in the body, that it isn't dangerous, how to tolerate it and to have techniques for some control.
3. *Negative thinking styles.* Here the adolescent is able to learn about the ways depressed feelings can automatically pull us into focusing on the negative views of the self, future and world. They may also be able to consider underlying basic beliefs arising from early life experiences and how to re-evaluate them. They can learn not to take their negative thoughts at face value, consider alternatives and look more towards, and build on, their strengths. In addition ruminative style can be a focus for intervention.
4. *Working with problematic behaviours.* Various forms of avoidance can be a special problem for adolescents and work here can help them develop strategies for engaging in, and with, any difficulties they might have. Coaching and mentoring can be especially helpful with encouragement to engage behaviours that have been avoided. In doing so the adolescent can gradually regain their confidence.
5. *Problem solving.* This involves helping adolescents break problems down into 'doable' and 'achievable' chunks. In addition the therapist and adolescent can brain storm together various solutions for problems. They can also focus on easy to do and short-term problems versus more complex longer term problems. The therapist may help the adolescent recognise and cope with basic dilemmas.
6. *De-shaming emotions.* Many adolescents can feel ashamed of changes in their bodies and changes in feelings. Negative beliefs that one's emotions are confusing, overwhelming, are not shared by others, should not be revealed to others, are shaming and/or that one can lose control to them, can be sources of great distress. Adolescents who lack open, empathic relationships in which they can discuss and learn about emotions can have a sense of alienation and difference as a result of their emotions as well as a fear of them. Perhaps the most obvious anxieties can be around sexual feelings and orientations.
7. *Assertiveness and relationship bullying.* Shy children are more vulnerable to bullying and depression than non shy children. Sometimes therefore it is important not only to have clear anti-bullying procedures within schools but also have opportunities for young adolescents to attend assertiveness and relationship building classes. Adolescents who lack these skills may enter their first intimate relationship with problems of relationship building and become somewhat submissive or bullying in these relationships. Helping adolescents acquire relationship building skills can be helpful because relationships are known to be powerful regulators of physiological state and affect.
8. *Special help for working with traumatised adolescents.* A sizeable number of depressed adolescents will have come from, and may still be in, abusive family relationships. Issues of shame and fear can permeate problems associated with abuse and require sensitive handling. These children need careful assessment with appropriately delivered support and therapies by professionals who are familiar with these difficulties.
9. *Medications.* Medications are not recommended as usual first line interventions for mild depressions and will only be considered and provided by people clinically trained in their use.

What Helps

For mild depressions some adolescents will benefit from having a confidante they can talk to. If problems are related to academic difficulties and problems such as dyslexia, identification of the specific difficulties and appropriate educationally support can be helpful. Well supported anti-bullying procedures can be helpful. In regard to more formal and specific therapies for depression NICE suggests that cognitive behaviour therapy, interpersonal psychotherapy and short term family therapy can be effective. NICE also suggests that working with adolescent depression should be contextualised in the appropriate social environment which will mean working with the parents.

We need to keep in mind that depression is a heterogeneous disorder with large individual differences and therefore to be wary of treatments around 'one size fits all'. There are range medications, psychological and social interventions that may help the adolescent. For example, for some, individual therapy may help while for others family therapy may be helpful and yet others may find, working in a group helpful. Some interventions for (say) raising self-esteem can be carried out in schools. All formal therapies should be provided by those appropriately trained in their delivery.

Conclusions

There are many debates over whether mental health problems are increasing in adolescents and the reasons for why this might be the case. A number of reports have raised concerns about a range of factors such as changes in diets, family dynamics, increased pressure for educational attainment, the role of the media and role models, the shift to computer based entertainments, and break down in childhood relationship building opportunities. There is evidence that societies that are more materialistic and competitive, compared to those that are more welfare focused, have higher rates of mental ill health and crime.

The prevention, detection and early intervention in a childhood and adolescent depression should be a health priority, not only because of the high rates of the depression but also because many people suffering recurrent depression note that their first onset were in adolescence and early childhood. Depression may point to serious problems in their current relationships and can have major impacts on subsequent mental health, achievements, work prospects and parenting. Recognising the high rates of depression in adolescents and the warming signs alerts us to the need for better detection and avenues to obtaining appropriate care and treatment.

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APSA Practitioner Briefings are a new series of summary Briefing Papers issued by APSA on key topic areas in services for adolescents. The series is edited and produced by Ann Hagell and Keith Wilshere for and on behalf of the Association.