

Depression in adolescence

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Statistics concerning the prevalence of depressive disorders among adolescents are rare and imprecise (1, 2). In the United States, it is reported that between 3 and 40% of adolescents present anxio-depressive symptoms (3, 4). Moreover, the severity of depressive symptoms is hard to evaluate (5). However, a predominance of girls is always noted. Present data give us a partial and inadequate picture and the literature is still not clear on the following aspects: 1) the evaluation and measurement of depression among adolescents; 2) the distinction between temporary depressive symptoms and persistent depressive syndrome; and 3) the frequency of depression in adolescence. This article summarizes the data available on adolescent depression and suggests a clinical procedure to help professionals working with adolescents.

The problem

Several aspects of adolescent depression must be presented in order to better understand those who show up for a consultation.

The level of stress provoked by any event is function of: the type of event, the perception of the event by the person concerned and the coping capacity of the person (6). The events and the stress that underlie depressive reactions are perceived differently by adults and adolescents. Among adolescents, minor daily stresses (for instance, school work and appearance) can sometimes be as significant for them as major stresses (for instance, the death of a friend or the divorce of parents) (7, 8).

As among adults, the expression of depressive symptoms varies from one individual to the other. For adolescents, depression can also vary according to age and the level of psychological development (9). Kashani and his collaborators showed that, at the age of 8, social isolation and pessimism are often the expression of an underlying depression. Among 12 year-olds, somatic complaints are a frequent symptom of a depressive state while at about 17, adolescents more frequently have suicidal ideas coupled with irritability and aggressiveness.

The intensity of depressive symptoms is an important factor to consider but, at the same time, is hard to measure clinically. It is sometimes difficult to distinguish normality from pathology because of the emotional turmoil experienced during adolescence. The frequent mood swings of the 'normal' adolescent must be distinguished from long-term depressive states. However, the literature is vague on the definition of 'persistence' (i.e. feelings experienced 'most of the time' by the adolescent) (4). Intense and persistent depressive symptomatology is not a universal phenomenon of adolescence but rather the indication of a pathology.

The diagnostic criteria of depression as described in the DSM-IV must be analysed according to the global context of the individual's history. The manifestations of depression vary during adolescence and are not only limited to the classic symptoms of insomnia, fatigue and weight loss.

The use of DSM-IV criteria for major depression are restrictive, especially for adolescents, and Ryan suggests three additional criteria: social isolation, somatic complaints and despair. More importantly, depression often manifests itself by a disruption in the usual functioning of the adolescent, that is, a change taking place over a period of a few months in his behaviour, at school, with his peers or in the family.

Knowledge is lacking on the natural evolution of depressive symptoms among adolescents, especially regarding short-term suicidal risk (11, 12). However, it is believed that suicidal attempts will happen quite soon in a depression of rapid onset. All depressed adolescents do not make suicide attempts and all adolescents with suicidal ideas are not depressed.

DSM-IV: Major Depression

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.

- (1) 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;
- (2) 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);
- (3) 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;
- (4) insomnia or hypersomnia nearly every day;
- (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down);
- (6) fatigue or loss of energy nearly every day;
- (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick);
- (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others);
- (9) 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 (hypomanic and depressive).

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.

Taking the history

The complexity of the phenomenon as well as the lack of knowledge and precise diagnostic tools make it more difficult for the clinician to deal with a depressed adolescent. The following section will discuss some practical aspects, in order to help the professional working in a primary care setting.

The interview

Interviewing an adolescent can be somewhat difficult because of the characteristics inherent to that age group and the possible relational biases of the interview.

Adolescents go through several phases and tasks unique to this period of life. The task of distancing themselves from the parents can increase the tension with the family and possibly with parental authority figures. Identification with gang values and behaviours can clash with adult values. Moreover, adolescents don't have the full capacity to project themselves in future and to fully perceive the consequences of their behaviour. Thus, the level of development will influence the evaluation of at-risk behaviours, compliance to treatment and the need for closer follow-up.

The characteristics of the clinician/patient relationship include many possible relational biases. The appearance of some adolescents can be disconcerting for the clinician. Sometimes, the scarce vocabulary of adolescents requires the professional to reorganize the interview using choices of answers rather than broad statements or questions (tell me about your life, or tell me about your feelings...). Feelings that are confusing and contradictory for the adolescent must often be expressed in words by the interviewer. Apart from the fact that it can be hard for them to clearly express their thoughts, adolescents often feel we do not believe them (13). Yet the literature shows that adolescents rarely manipulate and that they will seek out a tolerant and dependable person who will respect and believe them in their distress. Confidentiality is another potentially conflicting aspect of the clinician/adolescent relationship (14). In short, the clinician can feel disconcerted or annoyed with several aspects of the interview.

The reason for consultation

Several motives can push depressed adolescents to consult. They may consult directly for diverse complaints or they may also be referred by someone.

The most frequent reason for consultation is somatic complaint (headache, fatigue, back pain, etc.), but depression among adolescents can appear under the guise of behavioural problems, running away or suicidal attempts. Occasionally, anorexia nervosa can be the manifestation of a depressive state. Although these presenting complaints are not characteristic of any pathology, they should lead us to suspect a depressive state and guide our interview accordingly.

Data collection

The clinician analyzes the problem by asking proper questions. He verifies the presence, intensity

and persistence of the depressive, anxiety and somatic symptoms. Precise questions on the feelings and symptoms will bring reliable answers in order to clarify the diagnosis. The clinician must also eliminate through his interview and pertinent physical examination any organic cause of depressive symptoms (use of steroids, hypothyroidism , etc.).

After clarifying the symptoms, the clinician broadens the interview in search of minor and major stressful events and by exploring the functioning of the adolescent, especially in the following environment: school (relationships with teachers/principal's office, relationships with schoolmates, violence, drugs, acute and chronic stress in school); the 'network' (the gang, its style and culture, leisure time, close friends, drug abuse, sexuality); and the family. At the family level, the clinician looks for antecedents of depression or manic-depressive psychosis, and discusses the structure of the family, the relationships within the family, parenting style or recent stress in the family. The subjective perception of a depressed adolescent must be validated by parents. It is therefore important to meet them.

This information will reveal important events (divorce, violence, family problems, etc.) at the origin of a depressive state; it will be taken into account in planning the therapeutic approach.

Diagnosis

All this information, collected in one or several interviews, should lead to the diagnosis. The diagnostic approach for an adolescent is not different than for an adult, in that depression is a clinical diagnosis. Considering the present state of research, the DSM-IV classification remains the instrument on which to base a diagnosis of depressive state.

It is important to remember that of all adolescents who consult in a primary care setting with depressive feelings, only a few will be given a diagnosis of major depression after evaluation. Adaptation problems with depressive mood or other variants represent the most frequent diagnosis. For certain adolescents, it will be difficult to end up with an exact diagnosis but fortunately the evolution of their symptomatology will clarify it. Eventually, some of these adolescents will be given the diagnostic categories above-mentioned and others will be diagnosed with personality disorders, dysthymic problems or anxiety disorders. Some of them will never answer to the precise criteria of the DSM-IV classification; they are often normal adolescents who experience problems for which they only need a temporary support.

It is important to realize that a difficult interview with an adolescent can lead us to neglect the diagnostic aspect of the problem. However, the more exact the diagnosis, the easier and more adapted will therapeutic decisions be.

Treatment

Establishing a good and trusting relation is the most important aspect of the therapeutic approach. Support and listening are essential to help the adolescent clarify his emotions. Regular appointments should be planned. These visits will provide concrete solutions to situations perceived as troublesome. This supportive relationship is not different from the one in adults who present with adaptation problems, but the particularities of the interview described above remain constant throughout the therapeutic process. On a short-term basis, to focus on the adolescent's needs and problems will, in most cases, reduce the complaints. However, the clinician must

always be on the alert for suicidal ideation. Missing an appointment should not lead to suspect bad faith on the adolescent's part; it should rather lead, on the following visit, to a discussion of the reasons for the absence and the verbal agreement between the clinician and the adolescent.

Some specific interventions are also part of the therapeutic approach. For example, temporary absence from school or contact with school authorities can be important supportive measures, if taken after discussion and consent by the adolescent. The intervention with parents is also important. If it is the case, it could be necessary to tell the parents about a possible risk of a suicide attempt by their child. Parents will sometimes need support and information to better help their child. It is possible that they themselves need a therapeutic approach for unsolved problems. Moreover, there should never be any hesitation to refer an adolescent who deteriorates or fails to progress (for instance, psychotic depression or major depression).

Pharmacological agents used for adults can also be used for adolescents. Presently, there is little evidence of the efficacy of tranquilizers for adolescents, but they are prescribed for several anxiety disorders (16, 17, 18). Among depressed adolescents, they can be prescribed to control paralysing anxiety, for short periods (7 to 10 days), because of the possible risk of dependency. Furthermore, these drugs are safe and medication such as alprazolam (Xanax), lorazepam (Ativan), oxazepam (Serax) and clonazepam (Rivotril - paradoxical effects such as restlessness can appear) constitute good choices (16 to 19).

The use of antidepressants is limited to adolescents with major depression who do not show any improvement with the usual therapeutic approach described above. The intensity of associated neurophysiologic complaints such as insomnia, weight loss, attention deficit, points to using such a medication, as does a family history of depressive or mood disorders. Presently, the serotonin inhibitors are preferred to the tricyclic antidepressants, because they are better tolerated, easy to use, less harmful and equally effective. They should be started at minimal doses and increased progressively; they do not require blood dosage. Their antidepressant effect is perceived after a week. The adolescent must be informed about side effects and the sometimes unstable evolution at the beginning of the treatment (improvement followed by transitory deterioration).

In summary, a supportive relation remains the central aspect of the treatment of depressive disorders among adolescents. The prescription of antidepressants should not be routine. The decision to use these drugs depends on the analysis of each individual case, considering the severity of the symptoms, the pros and cons of the pharmacological treatment and the likelihood of providing a strict follow-up. Generally, when antidepressants seem necessary, it is suggested that a specialized psychiatric evaluation be done (20-21).

Conclusion

When adolescents present somatic symptoms, suicide attempts, running away or behavioural problems, the primary care clinician must consider a possible depressive syndrome and not reserve it as a diagnosis of exclusion.

The interview, the diagnostic approach and therapeutic intervention must be integrated in a global approach leading both to a good understanding and the solution of the problem(s). A holistic approach, focused on the adolescent and his needs, is presently the most promising. This global

approach could have a preventive effect on the mental health of the adolescent as a future adult.

References

1. Statistique Canada, Catalogue 84-203, éditions 1985 et 1987.
2. Ayotte V., Ferland M. Les jeunes adultes. Et la santé, ça va? no.2. Ministère de la santé et des services sociaux du Québec, Les publications du Québec, Gouvernement du Québec; mai 1989. 57p.
3. Kashani JH, Carlson GA, Beck NC et al. Depression, Depressive Symptoms and Depressed Mood Among a Community Sample of Adolescents. *Am J Psychiatry* 1987; 144: 931-934.
4. Garrison C, Schluchter Md, Schoenbach VJ, Kaplan BK. Epidemiology of Depressive Symptoms in Young Adolescents J. *Am. Acad. Child Adolesc. Psychiatry*, 1989; 28,3: 343-351.
5. Kazdin AE, Petti T.A. Self-Report and Interview Measures of Childhood and Adolescent Depression. *J. Child Psychol. Psychiat.* 1982; 23,4: 437-457.
6. Folkman, S., An Approach to the Measurement of Coping. *J. Occup. Behav.*, 1982; 3,1: 95-107.
7. McGuire DP, Mitie W, Newman B. La perception du stress chez les jeunes: les inquiétudes de l'adolescent normal. *Santé mentale au Canada*, juin 1987; 35, 2: 2-6.
8. Compas BE, Davis GE, Forsythe CJ. Characteristics of Life Events During Adolescence. *American Journal of Community Psychology* 1985; 13, 6: 677-691.
9. Kashani, JH, Rosenberg MA, Reid JC. Developmental Perspectives in Child and Adolescent Depressive Symptoms in a Community Sample. *Am J. Psychiatry* 1989; 146: 871-875.
10. Ryan ND, Puig-Antich J, Ambrosine P et al. The Clinical Picture of Major Depression in Children and Adolescents. *Arch Gen Psychiatry* 1987; 44: 854-861.
11. Moreau, D.L. Major Depression in Childhood and Adolescence. *Psychiatr Clin North Am* 1990 Jun; 13,2: p. 355-68.
12. Kosky R, Silburn S, Zubnick SR. Are Children and Adolescents Who Have Suicidal Thoughts Different from Those Who Attempt Suicide ? *Journal of Nervous and Mental Disease* 1990; 178, 1: 38-43.
13. Smith MS. Evaluation and Management of Psychosomatic Symptoms in Adolescence. *Clinical Pediatrics* 1986; 25,3: 131-135.
14. Tonkin RS. Suicide in Adolescence. *Canadian Family Physician* 1986; 32: 2437-2442.
15. Lapierre YD, Raval KJ. Pharmacotherapy of Affective Disorders in Children and Adolescents. *Psychiatr Clin North Am* 1989 dec; 12,4 : 951-61.
16. Gelenberg, AJ, Bassuk El, Schoonover SC. *The Practitioner's Guide to Psychoactive Drugs*. 3e ed. Plenum Medical Book Company, New York; 1991. 504 p.
17. Simion JG. Pediatric Psychopharmacology. *Can J. Psychiatry*, 1989 March; 34: 115-22.
18. Waters BG. Psychopharmacology of the Psychiatric Disorders of Childhood and Adolescence. *Med J Aust*, 1990 Jan; 152, 1: 32-9.
19. Biederman J. The Diagnosis and Treatment of Adolescent Anxiety Disorders. *J. Clin. Psychiatry*, 1990 May; 51 Suppl 20-6; Discussion 50-3.
20. Ryan ND. Pharmacotherapy of Adolescent Major Depression: beyond TCA's. *Psychopharmacol Bull*; 1990; 26, 1: 75-9.
21. Garfinkel BD, Carlson GA, Weller EB. *Psychiatric Disorders in Children and Adolescents*. W.B. Saunders Company, Philadelphia; 1990. 569 p.

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