Teenage depression: some navigational points for parents and professionals

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Adolescence is an expected time of turbulence, with most showing mood shifts. Key dilemmas for parents include whether any “depression” is “normal” or of concern, how to raise the possibility of any depressive disorder with their adolescent and, if assistance is required, how to access appropriate assessment. Dilemmas for professionals include judging whether they have the relevant expertise for assessing and managing, how to structure a diagnostic interview, how to “relate” to the adolescent, and awareness of diagnostic and management nuances, especially prescription of psychotropic medications.

While there have been several previous monographs and papers on this topic (e.g., 1-3), as well as meta-analytic reviews of treatment options (e.g., 4), this paper overviews our personal clinical approaches.

“NORMAL” VERSUS “CLINICAL” DEPRESSION?

There are no absolute boundaries distinguishing clinical depression from “normal” depression in adults. Clinical mood disorders are broadly more severe, persistent, impairing and more likely to be associated with gravid symptoms such as suicidal ideation. While the same holds for adolescents, differentiation is confounded further by the turbulence of adolescence itself, non-specificity of some symptoms and the extent to which the adolescent lacks psychologically mindedness and “openness” to assessment.

While weighting the same parameters adopted in adult assessments, there are some useful “signals”, particularly if the adolescent is resistive to interview. For example, distinct asocial behaviour (e.g., not mixing with friends, not replying to text messages, remaining in their room) or loss of “light in the eyes” suggests a more severe condition. Predicting suicidal risk in adolescents is as difficult and imprecise as for adults, but more complicated by the reality that their suicidal messages may simply reflect low-risk adolescent existential despair or be a high-risk warning. Professionals should not be concerned about risking “false positive” judgments (that is a fact of professional life) and, if in doubt, weight their management to a “worst case” scenario.

RAISING THE POSSIBILITY OF A MOOD DISORDER

It is right and appropriate for parents to directly raise their concerns with their adolescent child or, if the parent-child communication lines are poor, another fami-

ly member (e.g., sibling, grandparent) or a close friend of the adolescent might accept enquiring gently. The aim should be to have concerns raised, to indicate the signs that have generated concern and to encourage a “conversation” with the adolescent to determine if professional assessment is warranted and by whom – ideally obtaining some agreement about each issue.

Assessment options range from generic support service (e.g., school counsellor) to general health services (e.g., primary practitioner) to specialist mental health service (e.g., psychiatrist). Coercing an adolescent to have an assessment or “tricking” the adolescent (e.g., not explaining that they are consulting a psychiatrist until at the professional’s rooms) is counter-productive.

PROFESSIONAL ASSESSMENT

The optimal assessment model is for the health practitioner to start by explaining that he/she is undertaking a confidential interview, and that, while he/she may then wish to interview parents, the adolescent will be invited to nominate issues not to be raised.

The interviewer should relate as authoritatively and warmly to the adolescent as he/she would to a young adult interviewee and reject any attempt at a “parity” model (e.g., adopting an adolescent argot of “cool, groovy”). The secondary interview of the parents ideally occurs with the adolescent in the room, and with the interviewer first seeking to obtain the parents’ impressions of their child over time (both for salient information and to reduce any tension) before inquiring into their recent concerns. As managing most people with mood disorders (particularly adolescents) is a “team game”, I favour the clinician *then* providing all parties with his/her views on diagnostic probabilities, a formulation and management recommendations, followed by a discussion clarifying and detailing each relevant component. Obviously it may be inappropriate for a particular parent to be involved in the process (e.g., if there is an issue of sexual abuse), while delicacy rather than demanding absolute open communication may be required when parents are uncomfortable about discussing some of their observations (e.g., suicidal messages, psychotic features) in front of the adolescent.

Review visits should focus on the adolescent’s and parents’ judgement about progress. Confidentiality is of key importance at each stage and the managing clinician should state the “rules” to all family members. The clinician

should appreciate feedback about progress from parents – whether at the clinic or, at times, independently. In latter instances, the clinician should state that, while he/she is able to be a “receiver” of information, to respect their child’s confidentiality, he/she is unable to be a “transmitter” in offline conversations. If an adolescent is at very high risk of killing themselves, such rules of confidentiality are outweighed by the risks, and the parents should be alerted and brought into selection of immediate management options.

DIAGNOSING THE MOOD DISORDER

The dominant diagnostic model underpinning psychiatric classification and the evidence base of treatments is the dimensional DSM model, which effectively contrasts major versus minor depressions, but also categorizes bipolar I and bipolar II conditions. In the trials of different drug and non-drug interventions for major depression in adults, all treatments appear similarly effective (5), a non-specific result reflecting “major depression” itself being a non-specific “domain” subsuming multiple depressive disorders.

Our contrasting preference (5) is a sub-typing model which positions some categorical conditions (e.g., psychotic and melancholic depression; bipolar I and II disorders) and a set of heterogeneous “non-melancholic” depressive conditions.

Unipolar psychotic depression is quite rare, while unipolar melancholic depression is somewhat uncommon in adolescents. In adults, a distinctive feature of those conditions is overt psychomotor disturbance (e.g., distinctly observable retardation and/or agitation). In adolescents, signs of psychomotor disturbance are less common and best assessed as symptoms. Students experiencing melancholia will report (like adults) concentration difficulties, finding study difficult and acknowledging that their brain feels “foggy”. There will be less light in their eyes and anergia (they just lie in bed in the morning) and diurnal variation of mood and energy (being generally worse in the morning).

While bipolar I disorder is also rare in adolescence, bipolar II disorder most commonly commences in mid to late adolescence and is seemingly becoming more prevalent – whether reflecting a true increase or greater awareness, better detection or improved screening. All adolescents being assessed for a mood disorder should be screened for a bipolar II condition.

Our approach to clinical identification of bipolar II disorder is to ask depressed adolescents if they have times when – neither depressed nor euthymic – they feel “energized and wired”. If acknowledged, we ask whether, at such times, they are more talkative and loud, spend money excessively and feel shame later, become verbally or non-verbally indiscreet, need less sleep without feeling tired, observe a disappearance of any general anxiety, feel invulnerable, become more creative and take risks. While DSM imposes a mini-

mum duration of four days, many adolescents report hypomanic episodes lasting hours to days. Their depressive episodes tend to be melancholic, albeit with “atypical features” of hypersomnia and hyperphagia over-represented.

The non-melancholic depressive conditions reflect the impact of significant life event stresses on certain attributional and personality styles, a model akin to adult disorders but with differing condition prevalences and some phenotypic variations. The personality styles of relevance include: a) anxious worrying (such adolescents are highly susceptible to depression before final school examinations); b) perfectionism (often again being vulnerable to exam stressors); c) social avoidance or severe shyness (the behaviourally inhibited teenager may become seriously depressed as a consequence of being bullied and “walked over”); d) rejection sensitivity (the adolescent is hypersensitive to judgement – praise or rejection – by others, and develops food cravings and hypersomnia when depressed); e) an intrinsically low self-esteem often due to emotional neglect in childhood, and f) a “self-focussed” style of poor impulse control and anger, which can risk aggressive and self-harming explosive behaviour during a depressed period.

In terms of stressors, as for adults, we can distinguish between “distal” and “proximal”, and between “acute” and “chronic” stressors, again showing some commonality with events experienced by adults, but also some being adolescent-weighted. “Distal” stresses include having an uncaring, violent or abusive (verbally or sexually) parent, while “proximal” stresses include any event compromising the individual’s sense of self-esteem or self-worth (e.g., humiliated by a peer, bullying and increasingly cyberbullying being key exemplars). Many of the non-melancholic depressive disorders in adolescence reflect an amalgam of acute and chronic life events. For example, having had a depressed mother and an indifferent father, being bullied at school for being “dumb” or “fat”, having the only supportive family member (e.g., grandmother) die or a school friend commit suicide.

TREATMENT GUIDELINES

General priorities are to identify the type of depression and assess the adolescent’s background and suicide risk, with a formulation shaping management, which in extreme high-risk scenarios may include hospitalization.

Most treatment guidelines are predicated on a dimensional (DSM or ICD) model differentiating depressive conditions by severity. A representative document was prepared by the Australian organization named *beyondblue* (6). In essence, it recommends: a) monitoring, support and possibly cognitive behaviour therapy (CBT) or interpersonal psychotherapy (IPT) for dysthymia or “mild” to “moderate” major depressive disorder, and b) CBT/IPT or fluoxetine (if necessary) for both “severe” major depression and treatment-resistant depression.

Our approach (5,7) prioritizes: a) combination of antidepressant and antipsychotic drugs for psychotic depression; b) an antidepressant drug – initially a selective serotonin reuptake inhibitor (SSRI) and, if ineffective, a broader-action antidepressant – for melancholic depression; c) a mood stabilizer (and possibly a low-dose antipsychotic drug initially) for bipolar I disorder and d) a mood stabilizer (preferably lamotrigine) or, on occasions, an SSRI for bipolar II disorder. For such “biological” conditions we also recommend 1000 mg of fish oil daily.

For the non-melancholic depressive conditions, we generally regard psychotherapy or counseling as the primary modality, with therapeutic choice weighted to the identified background (e.g., assertiveness training for the socially avoidant adolescent; IPT or counseling for a stress-induced depression; CBT for those with a low self-esteem or “atypical depression”). For adolescents with anxiety-weighted personality styles (e.g., anxious worrying, interpersonal rejection sensitivity), adding an SSRI may also assist by muting the “emotional dysregulation”.

Most current guidelines, including the *beyondblue* ones, note the risk of increased suicidal thinking and behaviours in adolescents exposed to antidepressants. While multiple explanations are possible, an antidepressant-induced serotonergic reaction appears a common linking factor (with its prevalence seemingly higher in adolescents than in adults). Thus, all antidepressants should be introduced at low dose and the adolescent (and family) warned about such a possibility and to taper and cease the medication if such symptoms develop.

CONCLUSIONS

Managing adolescent depressive disorders is somewhat more demanding than for adults, reflecting the concerns

brought by adolescents to any psychiatric assessment and treatment, their experiencing the “impact phase” of the condition, and their intrinsic preference to deny or minimize their condition. Establishing a therapeutic alliance will usually take longer. Adolescents who commit to managing their condition and “stay” with the therapist generally do very well (whatever their mood condition) and are highly appreciative of therapeutic attention.

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