

TREATING DEPRESSION IN TEENAGERS

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CASE

Leanne was just fourteen when she was admitted to a local paediatric ward, having taken 28 paracetamol tablets around six o'clock on a Sunday evening. The fact that she vomited and that her mother noticed this when she came to her room to ask her to turn her music down and realised what she had done probably saved Leanne from serious damage. When seen by the psychiatrist, she poured out a litany of feelings of self-disgust and low self-worth going back several years. She hated everything about herself: her appearance, her personality and her lack of intelligence, and felt things would never be any better in the future. At the same time, she expressed guilt for feeling this way when she had no particular problems in life or reason for doing so. She knew her parents cared about her and were interested in her (although she did think that they favoured her younger brother) but had never felt close to them and had long since stopped confiding in them. In fact, they irritated her. Not strong academically, she was happy to attend school for the social contact and had a good group of friends, although had recently been thinking that perhaps none of them really liked her. For about two months, she had been occasionally cutting her left arm with a blade, finding it temporarily relieved her self-disgust, but this relief was short-lived. Leanne had often considered taking an overdose but this was the first time she had acted upon the impulse. She could give no trigger cause for doing so, except that she had been feeling particularly low immediately prior to the incident. The only light her mother could shed on this was that Leanne had spent most of the previous 24 hours in the company of a particular friend who had come for a 'sleepover' and who had only recently left the house. The girls had both seemed quite cheerful and to be enjoying life whilst together. Leanne's mother was very concerned about her apparently troubled state, especially the cutting, but explained that it seemed to be intermittent, not constant. She very much regretted the way Leanne did not confide in her, and added that she could also be very irritable, demanding and quite nasty towards all family members.

This is a real and recent case presenting to Child and Adolescent Mental Health Services (CAMHS); only the name has been changed. It incorporates some of the common issues specialist CAMHS are presented with in current practice.

CONCEPTS OF DEPRESSION

It used to be the prevailing view that depression rarely occurred in childhood or, if present, took a 'masked' form including less obvious symptoms such as somatic or behavioural problems, the latter phenomenon often described as 'acting out', ie expressing unhappiness by difficult behaviour rather than an overtly low mood. Now, however, it is increasingly recognised that significant depression does occur and is just as likely to be severe, resistant to treatment, long-lasting and with a tendency to recur over time as in many adults.

SYMPTOMATOLOGY

It is always important to make a distinction from 'normal' sadness as an understandable and usually short-term response to external events or stresses. The core symptoms of depression are a predominantly low mood (incorporating feelings of emptiness or flatness) plus a loss of a normal capacity to enjoy life (anhedonia), both enduring for at least two to three weeks. In addition, there is usually a number of other features, including a decreased ability to concentrate and make decisions, fatigue and other somatic symptoms, sleep disturbance, weight change and recurrent thoughts of death, suicidal ideation or behaviours. Specific cognitive features were summed up by Beck as the 'negative triad': a persistently negative view of themselves, the world and the future. These are as easily identified in young people as in adults, as in the above case.

ASSESSMENT

This may take several sessions to be confident of a firm diagnosis, but draws upon detailed interviews with the parents or caregivers, the young person and often information from key teachers. Research on structured interviewing has made it clear that there are symptoms likely to be under-reported by parents alone, eg feelings of hopelessness, suicidal ideation and, less commonly, second person auditory hallucinations. The correlations between parental and child reports of symptoms are usually low. Over recent years there has been a burgeoning of standardised self-report questionnaires focussing on depressive symptomatology, eg the Children's Depression Inventory (CDI), the Beck Depression Inventory (an adult questionnaire, but useful for older adolescents) and the Recent Moods and Feelings Questionnaire. These have value as supportive information but do not have absolute validity. No single measure assesses all features and should never replace a carefully structured face-to-face interview with the patient. They seem to have a more useful function as pre- and post-treatment measures.

EPIDEMIOLOGY

Precise epidemiology is difficult to interpret because of differing definitions of 'caseness' but current estimates (probably underestimates) are of a point prevalence of 0.5-2.5% in prepubertal children and 2-8% in adolescents.

Before puberty, the sex ratio is approximately equal. By adolescence there is a clear preponderance of females, as in adults. There is some evidence that depressive disorders are becoming more common over time, but it is difficult to be sure whether this is a real increase, or represents better detection rates, coupled with a loss of stigma in accessing mental health services. It seems clear that there has been a definite increase in the prevalence of deliberate self-harm of various kinds in this age group over recent years.

PREDISPOSING AND PRECIPITATING FACTORS

As in adults, depressive disorders in young people are heterogeneous in aetiology. There is ample evidence of a genetic basis in some cases, strongest in bipolar disorder. A history of early adversity, especially separations from caregivers, is common, as are other disturbances of social relationship, especially a poor confiding maternal relationship, as in the case study. Much research has gone into the significance of recent adverse life events, especially those associated with loss of key relationships by death, illness, marital separation or divorce.

Teasing out contributory background factors of this kind helps in formulating an approach to treatment/management in individual cases.

TREATMENTS

A) PSYCHOLOGICAL

1 Individual approaches

a Cognitive behavioural psychotherapy

This approach has come to be recognised as the most useful practical psychotherapy in depressed adults and is adaptable to many adolescents, although it does require quite a commitment and basic level of understanding on the part of the patient. The focus is on systematically identifying, analysing and changing the maladaptive (negative) cognitions which so commonly underlie the depressed mood. The elements are: self-monitoring of mood, negative cognitions automatically triggered by external events and leading to low mood, then cognitive restructuring (working at substituting corrective, ie more balanced, cognitions). Weekly sessions with the therapist draw upon diary-keeping and homework tasks. Additional techniques often incorporated include activity scheduling (increasing the amount of daily time spent in purposeful activity in an attempt to reduce the time spent in depressive rumination) and relaxation training, especially where there is a high level of associated anxiety.

b Social skills training

This is often best conducted in small groups of young people with similar problems and incorporates modelling (by therapists), role-play, performance feedback and positive reinforcement of improvement. Again, homework tasks are often provided.

c Interpersonal psychotherapy

This is a standardised approach focussing on relationships and life problems – in young people, these may include developmental tasks. There is a major disadvantage of a grave shortage of appropriately-trained and experienced therapists using this approach.

2 Family work and family therapy

Most young people remain involved with a family to some extent. It therefore makes sense to expect to involve the family in the treatment process in one way or another. It is acknowledged that this may not always be acceptable to either the young person or the family, and may need to be worked towards at a later stage in therapy rather than embarked upon immediately.

There are three principle varieties of what might be generally called ‘family work’:

- a straightforward advice and counselling about the nature of depression and its associated symptoms, especially when

the origins of the depression lie more in individual factors than in family issues.

- b using the family as a treatment agent, helping with positive affirmations, activity scheduling, general encouragement and perseverance with the therapy programme etc.
- c family therapy ‘proper’, in which there are clear contributing family factors involving distorted or dysfunctional relationships or practices and where the family is therefore the main focus for intervention.

B) DRUGS

1 Tricyclic antidepressants

The efficacy of these long-established antidepressant drugs in an adult population has been well-researched and estimated to be around 70% positive response. Equivalent studies in children/young people have been fraught with methodological differences, making them difficult to evaluate but a recent meta-analysis suggests a much less convincing response of no better than 40%. These drugs, of which the most commonly used preparations are amitriptyline and imipramine, are known to have a repertoire of side effects which can be troublesome enough to lead to discontinuing taking them. These include dry mouth, appetite suppression, postural hypotension and urinary retention. A more serious disadvantage is that they can be very toxic in overdose, having a specific and irreversible cardiotoxic effect.

2 Monoamine oxidase inhibitors (antidepressants)

This group of antidepressants seems to have a place in treating ‘atypical’ cases of depression in adults, ie where there is excessive anxiety, even phobic states, somatisation and a reverse pattern of diurnal variation. The need to adhere to a very strict diet because of the risk of the ‘tyramine’ effect producing sudden hypertension, coupled with the way many teenagers are naturally non-compliant, means that few child and adolescent psychiatrists would risk recommending these drugs.

3 Selective serotonin reuptake inhibitors (antidepressants)

Over the last decade, this group of antidepressant drugs has become preferred to the TCAs in treating adult patients, because of their relative lack of troublesome side-effects and safety in overdose. Their positive effect in depression is very similar to the TCAs. These features are the same in an adolescent population so that they have become the drugs of choice in this age group. Within the last year, however, there has been growing evidence that some preparations in this category, most notably paroxetine, are associated with an increase in suicidal ideation in under-18-year-olds. There is also some evidence of drug dependency amounting to addiction in some individuals. In December 2003 the UK Committee of Safety of Medicines banned the use of all SSRI preparations except fluoxetine in young people under the age of eighteen. The same advice was issued about the use of venlafaxine, a noradrenaline reuptake inhibitor which had come to be widely used.

4 Lithium

The use of lithium as a treatment (alongside major tranquillisers) in acute mania or as a preventative treatment for both depressive and manic episodes in bipolar disorder is well-established in adult patients and has a similar place in young people with this disorder.

C) ELECTROCONVULSIVE THERAPY

This has never been widely used in a younger age group,

especially under the age of sixteen. Recorded responses are variable and, on the whole, not impressive.

D) INPATIENT TREATMENT

This may become necessary when the depression is particularly severe or resistant to outpatient management, or where there is a threat to physical safety, such as persistent suicidal ideation or self-harming behaviours, or damage to health such as eating or drinking inadequately. Such a course of action may also be indicated where a supportive network is lacking or the family is not coping.

Unfortunately, an appropriate admission is not easily achieved with a national shortage of adolescent inpatient units and keen competition for very few places. Most adolescent units are able to offer a full range of the treatment approaches outlined above as well as the most general advantages of 24-hour supervision and respite from any stresses in the home environment. If such an appropriate placement cannot be found, admission to an adult unit may be necessary on safety grounds, but is usually second-best in meeting the youngster's needs.

OUTCOME AND PROGNOSIS

Most young people with significant depressive episodes eventually recover, although this can take up to two years. It is variously estimated in outcome studies that 50-75% have recovered within the first year and 90% by the end of the second year. A minority, however, do seem to become chronic from their first episode, with continuing symptoms after two years. More importantly, there is convincing evidence that young people diagnosed as depressed are at increased risk of

subsequent episodes of depression later in life. This finding does not just apply to those with a family history of mental disorder. It seems to strengthen the case for identifying as early as possible and treating as energetically as can be achieved, those young people first presenting to specialist services in childhood and adolescence.

The size of the problem and meeting the need

There is a national shortage of consultants in psychiatry, including child and adolescent psychiatry, with an estimated 20% unfilled posts, worse in some areas (including ours) than others. Of over 700 new referrals to Morecambe Bay CAMHS in 2003, about a third fell into the 13+ age range, and of these up to half are referred because of depressive symptomatology, with or without deliberate self-harm. These cases are usually first assessed within days, or a few weeks when there is no evidence of self-harm. Treatment is potentially labour-intensive. Apart from a few of the self-harm cases where short-term crisis intervention is required, most significantly depressed youngsters require individual session every one or two weeks for several months, plus, in addition, some family input. Complete 'cures' are rare, and even after sufficient improvement leads to negotiated discharge, unfortunately, re-referral due to a degree of relapse is common later.

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During the 12 months leading to July 2003, there were 34 emergency admissions to the paediatric ward at RLI with deliberate self-harm or overdose. FGH had 22 admissions during 2003, but there appears to be a sharp increase this year.

There has been one fatality in the past five years, following a paracetamol overdose.

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