Depressive disorder in adolescents

Depressive disorder in adolescents - F32#* (Clinical term: Depressive episode Eu32) * The current ICD-10 classification does not distinguish between adults and adolescents.

Introduction

Depressive disorder in pre-adolescents is very rare and difficult to distinguish from the intense emotional reactions and misery that are common in small children. All cases of suspected depressive disorder in pre-adolescents should be referred. This guideline is concerned with depressive disorder in adolescents.

Presenting complaints

Adolescents usually present with symptoms of depressive disorder such as depression, suicidality or sleep disturbance. Depressive disorder can also present with its complications (eg school refusal) or with co-morbid problems (eg behavioural difficulties). Adolescents frequently present with physical symptoms, such as headaches or abdominal pain. Irritability can also be a symptom of depression.

Diagnostic features

Depression is diagnosed using the same criteria as in adults.

- Low or sad mood is present most days.
- Loss of interest or pleasure is present most days.

As well as several of the following associated symptoms:

- Hopelessness
- Poor concentration
- Poor or excessive sleep for developmental stage
- Weight loss (or failure to gain weight normally) or excessive weight gain
- Suicidal thoughts or acts
- Low self-esteem
- Loss of energy
- Agitation or slowing of movement or speech.

To qualify for a diagnosis of depressive disorder, these symptoms should lead to significant suffering or impairment and should persist for at least one month.

Several factors increase the risk of depression, and their presence should alert the practitioner to the possibility of this diagnosis. These include being in care, recent bereavement, family breakdown, and adolescents with shy personalities who have peer relationship problems.

Differential diagnosis and co-existing conditions

- Anxiety disorder (Depressive disorder should only be diagnosed if the symptoms are clearly prominent and not part of an anxiety disorder).

- Normal adolescent emotionality (Depressive disorder should only be diagnosed if there is social impairment, or there are serious symptoms such as a suicidal attempt).
- Conduct disorder - F91# (depressive disorder should only be diagnosed if the symptoms are clearly prominent and not part of the behavioural disorder).
- Drug use - F11# (diagnose depression as secondary if it occurs only in conjunction with heavy substance abuse [eg misuse of marijuana]).
- Bipolar disorder - F31 (adult) (in referred samples about 1 in 20 adolescents with severe depression go on to develop bipolar disorder; the risk is higher if there are features of psychotic depression and a family history of bipolar disorder).

Some medications used by adolescents, eg preparations for acne, oral contraceptives and corticosteroids, can be associated with depression.

A wide range of problems can occur in conjunction with depression, which makes the diagnosis more difficult. Symptoms of general or separation anxiety (fear of being away from a major attachment figure) are frequently present. Other co-morbidities include behavioural problems, substance misuse, school attendance problems and family difficulties.

Essential information for patient and family

- The adolescent is not making the symptoms up. What look like laziness or crossness can be symptoms of depression.
- Depression can affect relationships within the family and the ability to do school work or to go to school.
- Effective treatments are available for depression, and there is a good chance of recovery.

General management and advice to patient and family

(ref 261)

- Identify current life problems or stresses and try to reduce them.
- Try to keep the adolescent active by planning enjoyable activities with them.
- If the depression is not severe, encourage the adolescent to go to school.
- Encourage the adolescent to take exercise, to get to bed early and to eat a balanced diet.
- If the adolescent has made a suicidal attempt, the parent should be encouraged to secure medication and sharp objects. Offer the patient and family an emergency telephone number (see Deliberate self-harm).
- Involve both patient and family in discussing the advantages and disadvantages of psychological and physical treatments. Many adolescents and families are worried about taking antidepressant medication, so respect this decision and continue to monitor.
- Individual psychological treatments, such as cognitive behavioural therapy and interpersonal therapy, are the treatment of first choice, if available.
- Family therapy has not been found to be effective, but might be indicated if family problems are obviously contributing to the adolescent's depression.
- Response to the initial treatment usually occurs within eight weeks. If it has not, consider a second line of treatment.

References

261 NICE will publish a guideline on the management of depression in children and adolescents in March 2005.

Medication

(ref 261)

- In general, medication is not the first-line treatment.
- Consider antidepressants, however, if the depression is so severe that psychological treatment is unlikely to work by itself, if non-medical treatments have failed or are not available.
- Tricyclic antidepressants should be avoided - there is little evidence they are effective in adolescent depression and they are dangerous in overdose.
- SSRIs are the first-line antidepressants.
- Start with half the adult dose and increase slowly, as adherence is particularly poor in this age group and perceived side-effects are the most common reason for not taking medication.
- Explain that the medication must be taken every day, that improvement in symptoms takes three to four, and that there may be some mild side-effects but that these usually fade within two weeks.

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Referral

Referral may be necessary if structured psychological therapies are not available in primary care.

Referral to a Child and Adolescent Mental Health Service is advised:

- in an emergency, when there is a high risk of self-harm, psychotic symptoms, or refusal to drink
- if depression persists despite initial treatment in primary care
- if the depression occurs in the context of complex family or social difficulties
- if the cause of the depression is likely to include abuse
- if the depression is co-morbid with severe behavioural disorder or substance abuse.

Resources for patients and families

Young Minds Trust 020 7336 8445
Parent information service: 0800 018 2138; website: http://www.youngminds.org.uk
Aims to improve the mental health of all children and young people. Produces a range of leaflets for parents and young people.

Change our Minds http://www.changeourminds.com
A website run by the Samaritans targeted at a younger audience.
A leaflet is available from the Royal College of Psychiatrists (http://www.rcpsych.ac.uk):
Depression in children and young people

So Young, So Sad, So Listen by P Graham and C Hughes. Gaskell Press, 1995.
A book discussing childhood depression.