Depression in Young People

What it looks like, When to Worry, What to do

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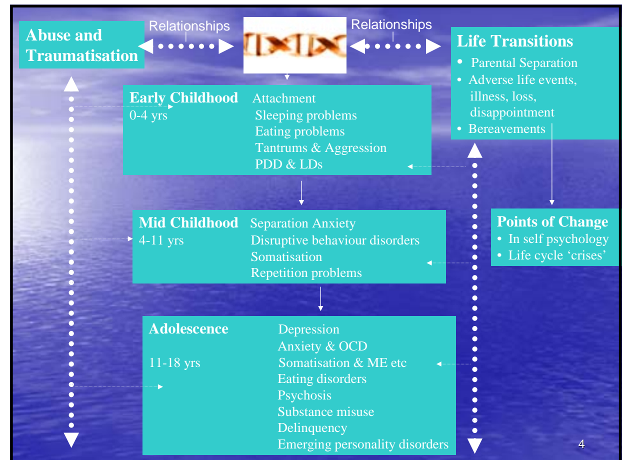
Outline of Workshop

You can choose what we will focus on

- Recognising depression and why it matters (Slides 4-28)
- Detection issues, Care Pathways & Barriers to detection (Slides 29-33)
- Intervention starts with listening: key concepts (Slide 34-36)

Outline of Workshop II

- Consent and confidentiality (Slide 37)
- Formulation; putting the story together (Slides 38-41)
- Risk and risk barometer (Slides 42-49)
- Interventions & Use of medication (Slides 50-60)
- References (slides 61-65)



Core Elements of Depression

- Mood
- Motivation-Interest
- Energy
- Sleep
- Concentration and attention
- Distortion of Cognitions
- Self harm

Identification

- "I felt as if no one could like me. I began to wonder just what was the point of anything. At first I lost interest in everything. I felt tired all the time and didn't sleep properly. I would wake up before the rest of the family and lie there feeling grotty and forgotten by the whole world. It felt as if everything was darkness and full of nothing, stretching out to the horizon and filling every corner"

Diagnosis

- You will miss depression in children and adolescents if you do not interview them directly yourself
- Standardised self report questionnaires such as the Mood and Feelings Questionnaire help (Angold and Costello 1987)

Diagnosis

Diagnosis depends on **symptoms** meeting **thresholds**

- Must be present more than half the time
- Must be causing clinically significant impairment
- Must have been present for at least 2 weeks

Developmental Considerations in Assessment and Treatment

- Don't expect the same melancholic presentation as you do in adults
- If you do, the threshold you set is too high, and you will miss cases
- Look for qualitative shifts across time in symptomology

Developmental Considerations in Assessment and Treatment

- Adolescents are much less likely to say "I cant concentrate", much more likely to say "school is no good" or "I am getting told off in class"

Developmental Considerations in Assessment and Treatment

- To assess and diagnose accurately
- We need to look "under" the presenting problems

Developmental Considerations in Assessment and Treatment

- Children and adolescents rarely have the developmental sophistication to say "its my concentration doc"
- That is our task, and that is what makes assessments different, we must allow for that and ask the appropriate questions

Developmental Considerations in Assessment and Treatment

- **loss of interest** expressed as "always bored" loss of energy and anhedonia, as loss of friendships and isolation
- **Loss of concentration** as school academic decline

Developmental Considerations in Assessment and Treatment

- **Depression and irritability** as impaired relationships in the family
- **Self harm** as an expression of **hopelessness, negative self worth** and perhaps **suicidal ideation**

Identification

The hallmarks of depression are

- Withdrawal
- Lowered mood tone
- Negativity

Identification

- Drop off in school work
- Change in peer group to more morbid preoccupied group or more deviant group
- Increased isolation from friends
- Increased isolation from family
- Increased confrontation with family or friends or school
- Changes in appetite and weight

Depression mediating Losses of Relationships

Identification

- Sleep dysregulation not just early morning waking
- Loss of confidence or self esteem
- Anxiety and avoidant behaviour like school refusal
- Morbid world outlook
- Self harming ideas

Identification

- Self harming behaviours
- Loss of usual get up and go, lethargy

Identification

- Myth of ordinary low mood of adolescence
- Myth of growing out of problems-implying no need to listen or make changes
- Myth of all adolescents want to isolate themselves from their families
- Myth of all families having major and repeated conflicts with adolescents

Identification

- Risk of pathologising normality
- Risk of pathologising normal grief and upset
- Risk of paralysing adaptive systems in the family or school or peers with a diagnosis of depression
- We want to enhance protective and help orientated behavioural strategies

Identification

- We want an activated patient and family
- Not a passive and de-skilled family waiting for us to do it all to them
- BUT we must know what it is that needs doing
- AND we must not encourage those parts of current behaviour that contribute to the problem

Diagnosis

In ICD 10 it is

- 4 or more symptoms
- Where 4 = mild depression
- Where 5/6 = moderate depression
- Where 7/8 = severe depression

Diagnosis

- Present for the same 2 week period
- Each represents a change from previous function
- One symptom must be either Depressed Mood OR Loss of Interest/pleasure (anhedonia)

Diagnosis

- Not clearly due to a medical condition,
- Each symptom must occur on most days and for the majority of the day

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Diagnosis

1. Depressed mood or irritable mood
2. Decreased interest/pleasure
3. Fatigue or loss of energy

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Diagnosis

4. Loss of confidence or self esteem
5. Feeling worthless, or excessive guilt
6. Recurrent thoughts of death, recurrent suicidal ideation, or behaviours
7. Decreased concentration or ability to think, vacillation, indecision
8. Psychomotor agitation or retardation
9. Insomnia or hypersomnia nearly every day
10. Significant weight loss or gain, or failure to gain expected weight

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Diagnosis

Psychotic subtype (usually very severe cases)

- **Mood congruent delusions or hallucinations**
- For example; guilt, hypochondriacal, nihilistic

- **Depressive Stupor**
- Not self caring, not drinking or eating or getting up

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Epidemiology

- Depression is much more common in adolescents than children
- Rates of diagnosis/prevalence 14-16 yrs are 3-5% hence approaching adult rates
- In childhood 8-11 yrs around 1 %
- In childhood boys rates = girls

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Epidemiology

- In early adolescence 12 yrs + girl's rates exceed boys
- by 14 yrs it is 2:1

High Comorbidity in 70-90%

- Anxiety Disorders 60%
- Conduct Disorder 25%

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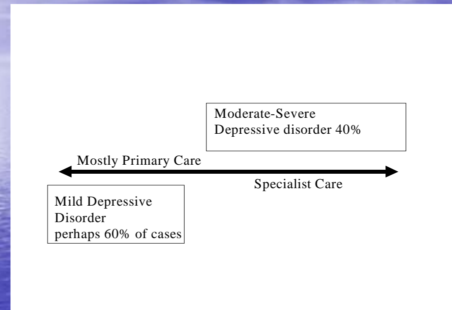
Detection

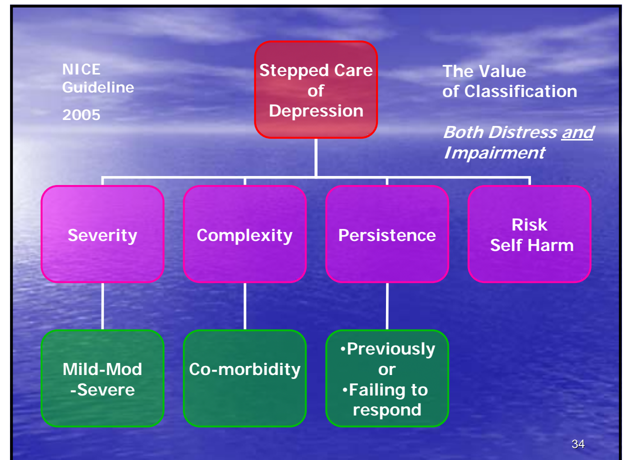
- At best 15% of cases are detected!



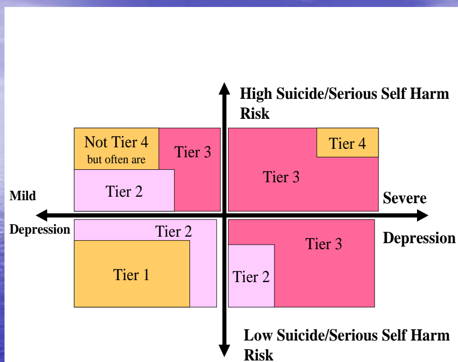
NHS
National Institute for Health and Clinical Excellence

The stepped care model

Focus	Action	Responsibility
Detection	Risk profiling	Tier 1
Recognition	Detection in presenting children	All tiers
Mild depression including dysthymia	Watchful waiting Non-directive supportive therapy/group cognitive behavioural therapy, guided self-help	Tier 1 Tier 1 or 2
Moderate to severe depression	Brief psychological intervention +/– fluoxetine	Tier 2 or 3
Depression unresponsive to treatment/recurrent depression/psychotic depression	Intensive psychological intervention +/– fluoxetine	Tier 3 or 4



Multidimensional Representation of stepped care classification



Two Dimensions: Depression Severity and Risk of Self Harm

Key Concepts In Depression, Suicide & Deliberate Self-harm

- Good case formulation is key
- Repeated risk and mental state assessment can be detrimental
- Stepped care model to fit risk/severity and complexity to provision
- To assess and manage we MUST speak to the young person personally
- We can make a difference by skilful listening and engagement

Intervention Starts With the Assessment Process & Types of Communication

- Look, listen, really listen, what is it really like in their shoes, check you have understood
- Problem solve carefully, don't expect all solutions to be accepted, offer them

Intervention Starts With the Assessment & Communication

- Use your inherent capacity to elicit the patients own "placebo" responses, you can really matter to a young person if you care to
- Be honest and open , don't over promise but don't miss real opportunities either

The Importance of Consent & Confidentiality

- Be honest about what you can realistically deliver in both time and expertise
- Be clear about confidentiality boundaries and safety issues:for example, risk of self harm, reports of child maltreatment etc

Formulation

A formulation covers the following areas: a summary of presentation; a statement regarding diagnosis and differential diagnosis; a statement regarding risk; a statement of possible aetiology and of evidence of resilience and protective factors; a strategic decision about where and when to intervene based on a dialogue between the clinician, the patient and their parents or carers. It is crucial to understand *what has helped* as well as what makes things worse

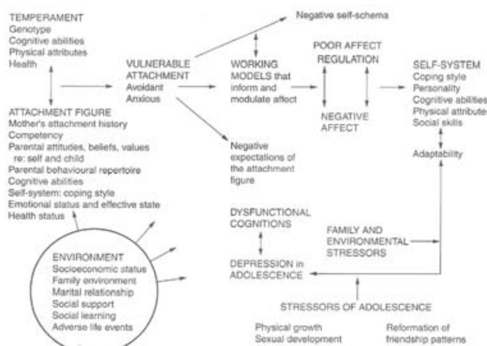
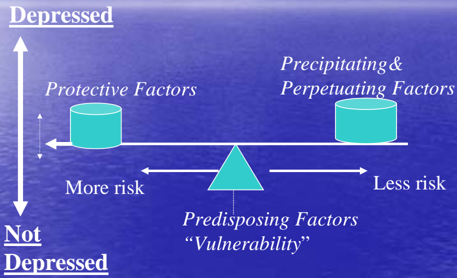


Figure 3.1. Factors affecting vulnerability to depression in adolescence.

'Formulation' Grid
to inform intervention strategy

Examples	**Physical Domain**	**Psychological Domain**	**Social Domain**
Predisposing Factors	Genetic family History	Negative view of self	Parental marital problems
Precipitating Factors	Sudden physical illness	Self too responsible	Parental separation
Perpetuating Factors	Temperamental style	Sense of guilt, impaired problem solving	Parental access disputes
Protective Factors	Good coordination-good at sport	Pleasure in achievements at school	Good relationship with at least 1 parent

Systems theory & depression: an example of interacting factors



Worry Barometers

Vignettes

- A 13 year old boy screams he will kill himself in the middle of an argument at home, there is a family history of maternal depression and personality problems
- A 15 year old girl says she wants to kill herself, and has been self cutting for 1 year intermittently
- A 15 year old boy says he wants to kill himself, he has become more distant, has peers, but not the same type of friendships as before and may be using drugs

Worry Barometers

Things that increase my 'Life Threat Barometer'

Risk of Suicide or death

- Increasing Isolation
- Increasing Severity of Depression, Psychosis, Eating disorder
- Rejection by family
- Entrapment
- Hopelessness
- Substance misuse
- Maleness
- Age
- Existential crisis
- Particularly with insight into severe mental disorder
- Recent loss crisis
- Disengagement

Things that decrease my 'Life Threat Barometer'

- A continued wish to change something
- Even if expressed in anger and conflict
- Engagement
- Hope
- The opposites of the previous
- Protective factors

Other Key Pointers to Problems in Adolescent Development

Look for....
- Change in sociability
- No sociability
- Dropping off in school performance
- Isolation in home or elsewhere
- Remember to reset your barometer to 'adolescents'
- We look for change across time-longitudinally-within the adolescent-not just absolute comparisons with 'external norms'

Assessing Suicidal ideation

- Content analysis: when, why, how often, what makes it better/worse
- Context analysis: effects of environment on patient: effects of patient on environment
- Associated diagnosis: can amplify risk
- Demographic and means

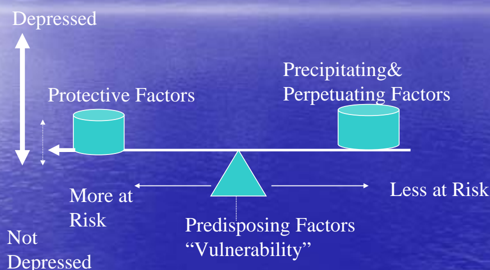
Assessing Suicidal ideation

- Information gathering and Clinical process
- Process can change presentation

Targets for Treatment derived from the Formulation

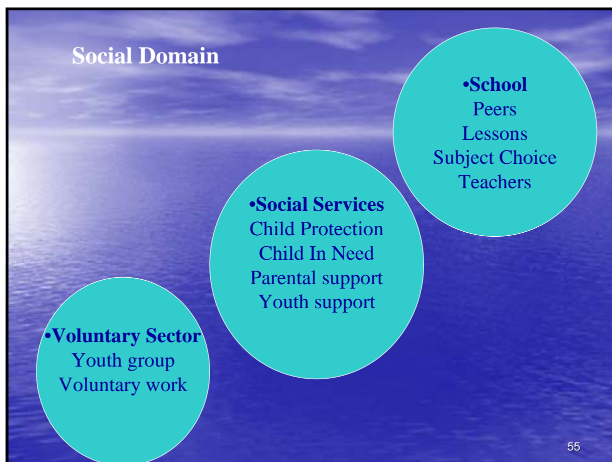
- This includes direct treatment of the depression **psychologically** and if necessary **psycho-pharmacogically**
- But also includes direct attention to factors in the environment such as **family, peers or school**

Systems Theory And Depression



Physical Domain
- Medication
- Diet
- Weight and fitness
- Exercise
- Sport ?competitive

Psychological Domain
- Effects of Cannabis
- Effects of alcohol
- Depression
- Achievement
- Recognition
- Validation
- Listening and Problem
- Solving
- Distraction
- Formal Therapy



Treatment at Tier 1

- With peers: consider bullying policies, consider conciliation/problem solving, changing sets/classes,
- Problems with home life: as in all cases where possible inform parents of your concerns as per policies: consider the value of a safe space to talk BUT don't promise undeliverables: "rescuing" & being the "good parent" etc

Treatment at Tier 1

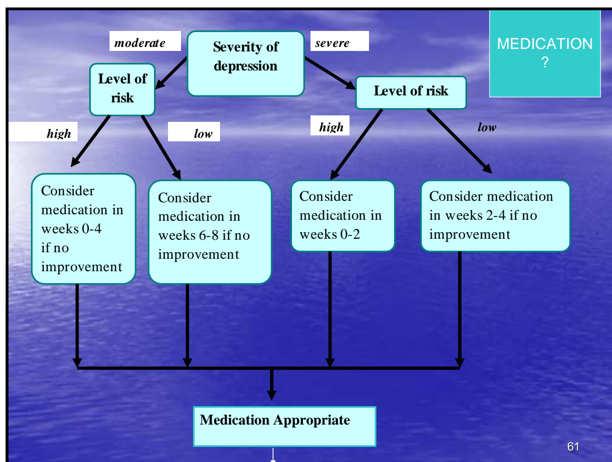
- Examine timetable for opportunities to improve self esteem and confidence in partnership with child and family
- Encourage reasonable and constructive activity, physical and mental

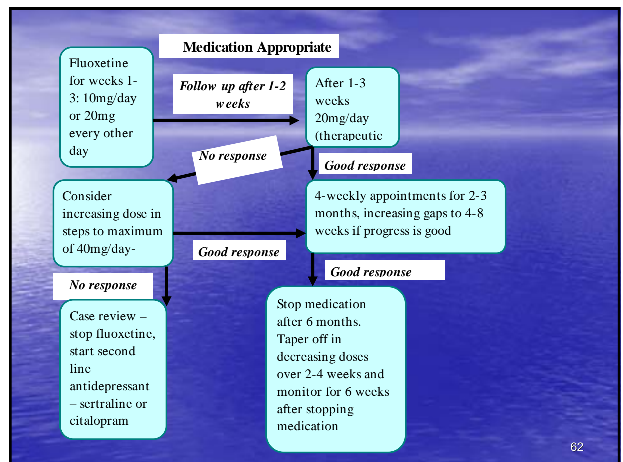
Treatment at Tier 1

- Discourage inactivity, BUT do not become punitive
- If the youngster can't do it or repeatedly engages in the same negative patterns THEN refer/seek specialised advice

Treatment at Tier 1

- REMEMBER-try, but not for too long, perhaps 12 weeks at the most if they are mildly clinically depressed and not at risk for other reasons
- Refer immediately if moderate or severe or at risk of DSH
- Always where possible seek to helpfully engage a parent in tandem with your efforts and keep them informed of what you are doing





References

- **ADAPT RCT 2008; A Randomised Controlled Trial of CBT in adolescents with major depression treated with selective serotonin reuptake inhibitors**; *Ian Goodyer, Bernadka Dubicka, Paul Wilkinson, Raphael Kelvin, Chris Roberts, Sarah Byford, Siobhan Breen, Claire Ford, Barbara Barrett, Alison Leech, Julian Rothwell, Lydia White and Dick Harrington. HTA NHS R&D HTA programme. HTA 2008; vol. 12 :no. 14*
- **Adolescence and Health:** Edited by John Coleman, Leo B. Hendry & Marion Kloep, John Wiley & Sons, Ltd. (2007)
  A tour around adolescence focussing more specifically on health related issues and ill health including physical and mental ill health
- Angold, A., & Costello, E.J. (2001). The epidemiology of depression in children and adolescents. In I.M. Goodyer (ed.), *The depressed child and adolescent* (2nd ed.), (Pp. 143-178). Cambridge: Cambridge university press.

References

- *Bridge JA, Goldstein TR, Brent DA.* Adolescent suicide and suicidal behavior. J Child Psychol Psychiatry 2006;47:372–394. [PubMed: 16492264]
- **Birmaher, B., Brent, D. A., Kolko, D., Baugher, M., Bridge, J., Iyengar, S., & Ulloa, R.E.** (2000). Clinical outcome after short-term psychotherapy for adolescents with major depressive disorder. *Archives of GeneralPsychiary, 57*, 29-36
- **Child Psychiatry**: Robert Goodman and Stephen Scott,Blackwell Science
  Good solid introduction to Child and adolescent psychiatry touchs on all the main areas of disorders, problems and assessment and treatment
- Hawton, K. & James,T. (2005) Suicide & deliberate self harm in young people: ABC of Adolescence series. BMJ vol 330, 16th April 2005 pp 891-894

References

- Graham, P. & Hughes, C. (2005) So Sad So Young So Listen; Gaskell Press
- Nice clinical guideline: depression in children and young people www.nice.org.uk & CG 038.
- **Practical Child Psychiatry, The clinician's guide:** Bryan Lask, Sharon Taylor, Kenneth Nunn (2003)
  Good solid introduction to Child and adolescent psychiatry touchs on all the main areas of disorders, problems and assessment and treatment
- The origins and course of common mental disorders: (2005) David Goldberg & Ian Goodyer. Routledge.

References

- The depressed child & adolescent; Cambridge monographs; Ed: Ian Goodyer, 2000.
- **The Nature of Adolescence:** John Coleman and Leo Hendry, The Nature of Adolescence (1999)
  A lovely tour around adolescence (normal)
- Unipolar depression; A lifespan perspective. Ed: Ian Goodyer 2003. Oxford university press.

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