Depression in Adolescence: an Overview

What We Know

› The *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (*DSM-5*), separates the disorders in the Mood Disorders chapter of *DSM-IV* into two chapters: Bipolar and Related Disorders and Depressive Disorders. There are seven depressive disorders that share moods characterized by sadness, irritability, or emptiness with related somatic or cognitive changes and distress that significantly interrupts functioning. The disorders are differentiated by the timing, duration, and cause(s) of the symptoms\(^{(1)}\)

› The Depressive Disorders chapter of *DSM-5* includes a new disorder, disruptive mood dysregulation disorder (DMD), that was added to address concerns about the overdiagnosis of bipolar disorder in children and adolescents. DMD must have onset of symptoms before age 10 and may be used for individuals aged 7-18. The primary symptoms are recurrent outbursts of temper that are out of proportion to the circumstances and the individual’s developmental level and that occur at least 3 times a week, with irritability or anger present most of the time between temper outbursts\(^{(1)}\)

› The *DSM-5* criteria for diagnosing major depressive disorder (MDD) in children and adolescents are the same as those for adults, with a couple of minor exceptions. *DSM-5* notes that MDD can occur at any age, but the start of puberty marks an increase in its rate of appearance. Diagnosis of MDD requires that at least five of the following symptoms be present for two or more weeks with at least one of the first two symptoms being present\(^{(1)}\)
  • Persistent sad or irritable mood
    – For children and adolescents irritability is more frequently the presenting symptom than sadness\(^{(5)}\)
  • Loss of interest in activities that once were enjoyed
  • Substantial change in appetite or body weight; in children or adolescents failure to make expected weight gains
  • Oversleeping or trouble sleeping
  • Psychomotor agitation or retardation
  • Loss of energy
  • Feelings of worthlessness or inappropriate guilt
  • Difficulty concentrating
  • Recurrent thoughts of death or suicide

› Current prevalence for MDD is estimated to be between 4% and 8% for adolescents who are between 12 and 18 years old. Lifetime prevalence of developing depression at some point in adolescence is higher at 13%–20%\(^{(5)}\)

› 90% of MDD episodes in adolescence resolve within 1.5 to 2 years from onset. Duration is on average 7 to 9 months\(^{(6)}\)

› Depression in adolescents is linked to poor academic performance, dysfunctional social relationships, substance use and abuse, and attempted or completed suicide\(^{(12)}\)

› Rates for relapse and recurrence with adolescent depression are high. Lifetime relapse estimates range from 34% to 75%. Recurrence rates range from 20% to 60% in years 1–2 after a remission from depression. After 5 years, this rate can increase to 70%\(^{(5)}\)
Members of ethnic and racial minority groups can be at an increased risk for depression as a result of social isolation, language barriers, unemployment, underemployment, trauma experienced in the home country prior to immigration, or cultural differences.

Lesbian, gay, bisexual, or transgender (LGBT) adolescents are at an increased risk of depression when compared to heterosexual adolescents and are overrepresented in suicide rates.

MDD is 1.5 to 3 times more common in females than males.

Depression is considered the most significant risk factor for suicidal ideation and completed suicides. In 2006 there were 4,189 completed suicides in the United States by individuals in the 15–24 age range, making suicide one of the leading causes of death for this age group.

Cognitive theory posits that suicide is triggered by the “cognitive triad”:
- An individual’s negative thoughts about self, the world, and the future form this triad
- An adolescent facing a stressful situation may think he or she has no worth (self), that the world is scary and unfair (world), and that there is no hope in his or her future (future)

Non-suicidal self-injury (NSSI) (e.g., cutting) often is present in adolescents with depression.

Depression often co-occurs with other mental health disorders in adolescents, including substance use disorders, eating disorders, anxiety disorders, obsessive-compulsive disorders, and conduct disorders.

Depression in adolescents should be viewed within the context of multiple systems (e.g., peers, family, school, community) and the interaction of the adolescent’s view of him- or herself and his or her place within those systems.

MDD can be triggered by the interaction of a stressful situation with risk factors that are present in an individual adolescent. The risk factors may be cognitive and/or environmental. They include:
- A parental history of depression
- Difficult temperament as a child
  - Impulsive
  - Shy
  - Easily upset
  - Irritable
- Attachment issues; parental emotional/psychological neglect
- Family discord
- Low socioeconomic status
- Post-traumatic stress
- Exposure to violence
- Frequent household moves or school transitions
- Physical and/or sexual abuse or neglect
- Poor peer relationships
- Loss of significant friendship
- Feelings of rejection
- Lack of confidence or perceived failure
- Discrimination based on race, ethnicity, and/or sexual preference

Protective or resilience factors can help mediate the risk factors that are present and lessen their impact on the adolescent. These include:
- Positive family connections
- Strong parent-child attachment or attachment with a caring and trusted adult
- Positive connections to school
- High academic expectations
- Healthy peer group
- History of positive coping in past difficult situations
- Easy temperament as a child
  - Adaptability
  - Sociability
  - Low intensity of reactions
What We Can Do

› Learn about depression in adolescence including risk factors, how to assess, consequences, and treatment options; share this knowledge with your colleagues

› Engage the adolescent client and establish a warm, therapeutic relationship

• Adolescents have expressed a need for therapists to be warm, caring, competent, and nonjudgmental

• Motivational interviewing can be useful for engaging adolescents in the therapeutic process

› Perform early assessments of any adolescent client to look for signs and symptoms of depression and/or suicide risk

• Utilize a prompt to structure a psychosocial assessment such as
  – HEEADSSS, which stands for Home; Education/Employment; Eating; Activities; Drugs; Sexuality; Suicide and depression; Safety. This prompt can serve as an informal outline for the social worker to use during the assessment phase

• Include in the assessment any relative rating scales, such as the Beck Depression Inventory II or Children’s Depression Inventory

• Include if appropriate a suicide risk assessment, which can include the following questions
  – Have you ever felt life was not worth living?
  – Do you think about your own death?
  – Have you ever thought about killing yourself?
  – How often do you think about killing yourself?
  – Have you ever tried to kill yourself?
  – What has stopped you from hurting yourself?
  – Is there someone you can tell if you feel like hurting yourself?
  – Do you have a plan?

› Educate adolescent clients on their privacy rights while working with the social worker and fully disclose to the client the limits of confidentiality. Discussing confidentiality early allows for trust building

• The limits to confidentiality often are referred to as the “three harms”
  – Harm to self
  – Harm to others
  – Harm from others

› Provide psychosocial treatment to the adolescent

• Interpersonal therapy looks at interpersonal disputes, role changes, interpersonal deficits, and family and relationship problems
  – Goals include improving communication skills, decreasing depressive symptoms by helping the adolescent have a better understanding of self, and improved problem-solving
  – Examines changes in parent-child roles
  – Seeks to improve or develop new social support systems, including changing peer groups when needed

• Cognitive-behavioral therapy focuses on specific skills with an education component. The main goal is for the client to learn coping skills to manage and reduce depressive thoughts and behaviors by actively keeping track of moods and controlling these moods
  – Educates the client about depression
  – Instructs the client to monitor his or her moods
  – Works with the client on cognitive restructuring
    – Replacing negative thoughts and designations (e.g., self-blame, criticism) with positive replacements
  – Teaches the client how to regulate emotions
  – Provides social skills training
  – May include instruction on relaxation techniques

› If appropriate, suggest that the adolescent be medically evaluated to determine if pharmacotherapy is indicated along with therapy. Type of depressive symptoms, severity of symptoms, and their impact on eating and sleeping can be indicators for antidepressant medical interventions. Use of pharmacotherapy should include consideration of the following: severity of depression, previous treatment(s), family members’/primary caretaker’s response, frequency and pattern of depressive episodes, response to psychotherapy, ability to pay for medications, and presence of psychosocial stressors

› Educate adolescent clients and families on the signs and symptoms of depression
Develop an awareness of our own cultural values, beliefs, and biases and develop knowledge about the histories, traditions, and values of our clients. Adopt treatment methodologies that reflect the cultural needs of the client. 

**Coding Matrix**

**References are rated using the following codes, listed in order of strength:**

- **M** Published meta-analysis
- **SR** Published systematic or integrative literature review
- **RCT** Published research (randomized controlled trial)
- **R** Published research (not randomized controlled trial)
- **C** Case histories, case studies
- **G** Published guidelines
- **RV** Published review of the literature
- **RU** Published research utilization report
- **QI** Published quality improvement report
- **L** Legislation
- **PGR** Published government report
- **PP** Policies, procedures, protocols
- **X** Practice exemplars, stories, opinions
- **GI** General or background information/texts/reports
- **U** Unpublished research, reviews, poster presentations or other such materials
- **CP** Conference proceedings, abstracts, presentation

**References**