

Quadrant II – Transcript and Related Materials

Programme: BACHELOR OF ARTS

Subject: PSYCHOLOGY, GE

Paper Code: PSG 102

Paper Title: Psychology of Adolescence

Unit: 4- Adolescent Sexuality and other Problems

Module Name: Problems in Adolescence and Prevention: Depression

Module No: 27

Name of the Presenter: MS. PRIYANKA RODRIGUES

Glossary of terms/words:

- **Antidepressant.** A drug used to treat depression. Selective serotonin reuptake inhibitors (SSRIs) are a class of antidepressants that includes drugs like citalopram (Celexa), escitalopram (Lexapro), fluoxetine (Prozac), paroxetine (Paxil), and Zoloft (sertraline)
- **Anxiety disorder.** A chronic condition that causes anxiety so severe it interferes with your life. Some people with depression also have overlapping anxiety disorders.
- **Bipolar disorder.** A type of depression that causes sometimes extreme mood swings between depression and mania (or hypomania.) This condition used to be called manic depression.
- **Depression.** An illness that involves the body, mood, and thoughts that affects the way a person eats and sleeps, the way one feels about oneself, and the way one thinks about things.

Possible misconceptions/clarification:

➤ **“Depression isn’t a real illness”**

Many people mistakenly believe that depression is mere sadness or even a weakness of character. But in fact, depression is a complex mental health disorder. It has social, psychological, and biological origins, and it can be treated in a variety of ways.

If you think you may be experiencing depression, don’t write it off as normal. Instead, talk to your doctor. They can help you get the support you need to manage your condition.

➤ **“Antidepressants always cure depression”**

Depression is treatable. Among other interventions, your doctor may prescribe antidepressant medications. These drugs alter your brain chemistry. They can help address deep-rooted biological issues that may be contributing to your condition.

But for many people, antidepressants alone aren’t enough. Your doctor may also recommend psychotherapy or talk therapy. Combining medications with talk therapy is a common treatment strategy.

➤ **“You can simply ‘snap out of it’”**

No one chooses to be depressed. Some people mistakenly believe that it happens when you allow yourself to wallow in your grief or sadness. They may think it can be cured with positive thoughts or a change in attitude.

In reality, depression isn’t a sign of self-pity, weakness, or laziness. It’s a medical condition in which your brain chemistry, function, and structure are negatively affected by environmental or biological factors. If you suspect you’re experiencing it, make an appointment with your doctor.

➤ **“It happens because of a sad situation”**

Everyone experiences sad thoughts or unhappiness sometimes. For example, you may feel upset following the death of a loved one or the end of a relationship. Events like these can raise your risk of depression. But depression isn’t always caused by a negative incident.

Depression can cause unexplained periods of hopelessness, sadness, and lethargy. You may also experience suicidal tendencies. These episodes can last for prolonged periods. They may arise suddenly and inexplicably, even when things in your life seem to be going well.

Case Studies and Additional Examples/Illustrations:

Lynda is a 16 year-old, white female admitted to Bradley Hospital on 10/3/00 because of active suicidal ideations manifested by holding a knife to her arm that morning. This was accompanied by thoughts of hanging herself by wrapping a telephone cord around her neck. Lynda has a history of suicidal ideation and has tried to cut herself in the past, but reported that the knife would not penetrate her skin. She was concerned that she would not be able to stop herself again.

In 1994, suicide among prepubertal children and young adolescents (5-14 years) in the United States involved approximately 322 deaths, and suicide among adolescents (15-24 years) involved approximately 4956 deaths. Thus, the risk of suicide rises substantially at puberty (1). Suicidal behavior is strongly associated with major depressive disorder or dysthymia, disruptive disorder, oppositional defiant disorder, conduct disorder, schizophrenia and developmental disorder. There is also a strong correlation between substance abuse and suicide among adolescents, but in this case, Lynda denied any substance abuse history (1).

Lynda reported depression for the past 2 years and an obsession with death since 8th grade. She is an obese female who appeared sad, making poor eye contact and demonstrating poor social skills. Her affect was flat and apathetic. Lynda reported difficulty sleeping, decreased energy, irritable mood and trouble with her appetite. She also reported significant feelings of worthlessness, helplessness and hopelessness. These include five of the symptoms which must be present during at least a 2-week period to diagnose a major depressive episode (2).

Major depressive disorder (MDD) is estimated to have a prevalence of 2% in children and 4-8% in adolescents. Though it presents in equal numbers in males and females in childhood, the male:female ratio is 1:2 in adolescence (3). MDD is frequently comorbid with dysthymic disorder (DD), a state of chronic depression which occurs for more of the day, or more days than not, in children for at least 1 year (3). This is significant because if DD occurs before 21 years of age (early onset), an individual is more likely to develop subsequent major depressive episodes (2).

In addition to the above symptoms, Lynda spoke about her imaginary friends, which she has had since 6 years of age. The characters are from television and movies, and she acts out their voices and argues with them. She recognizes that they are not real, but she will avoid her friends to spend time with her imaginary ones. She reported one auditory hallucination, a week before her admission, as a voice telling her to get out of bed to feel better.

These symptoms suggest psychotic depression, which is MDD accompanied by mood congruent or incongruent hallucinations. In adolescence these may be auditory hallucinations and delusions. Patients presenting with psychotic depression typically have more severe depression, greater long-term morbidity, increased resistance to antidepressant monotherapy, low placebo response, increased risk of developing bipolar disorder, and a family history of bipolar and psychotic depression (3).

Environmental factors are also linked to MDD (3). Lynda related that her depression had worsened in the past 2 weeks because her sister was living at home again. Her sister is abusive towards her (she started choking Lynda for using her television), and Lynda believes her mother does not punish her sister appropriately.

Lynda's parents are divorced. Her mother is a victim of domestic violence, and her father is an alcoholic. Also, her aunt is in an institution, and her cousin has tried to commit suicide. Children with at least one depressed parent have a three times greater risk of development of MDD, compared with a child with non-depressed parents. Parents of depressed children also tend to have higher rates of other psychiatric disorders such as anxiety, substance use and personality disorders (3). There is a prevalence of 30-50% of depression in first-degree relatives of depressed children (3).

Lynda was diagnosed at Bradley hospital with Axis I: Major Depressive Disorder Recurrent Severe with Psychotic Features and Axis V: GAF current 35 (highest in the past year 75). Axis II was not mentioned, but a learning disability was noted in her chart. She has asthma for which she takes albuterol, but this was not significant for classification under Axis III. Finally, though it was not mentioned, I believe she has several psychosocial and environmental problems based on the above information, which could be included in Axis IV.

Additionally, Lynda was given the diagnoses of psychotic disorder - not otherwise specified, schizophrenia probability disorder, and dysthymia. As mentioned above, DD is frequently comorbid with MDD. Schizophrenia is difficult to diagnose in childhood (4). It has been suggested that auditory hallucinations, delusions, and irrational or magical thinking are important diagnostic features (4). Lynda mentioned an interest in witchcraft, and she appeared for her interview dressed in black with her fingernails painted black as well. Schizophrenia in adolescents may have an insidious onset with apathy, a change in hygiene and withdrawal (5). Lynda's chart indicated poor self care; she was not showering. In addition, schizophrenia may coexist with learning disabilities, mental retardation, conduct disorder and autism (4). Lynda has been diagnosed with a learning disability. However, her imaginary friends are not really hallucinations as she actively makes their voices. She has

reported a single auditory hallucination. There is not enough information for a clear diagnosis, which is common in the early stages of the disease (2).

Antidepressant treatment was recommended for Lynda, but her parents refused. They consented to close follow-up for their daughter. There has been little research on treatment of MDD in children, so most treatment, efficacy and safety data are extrapolated from adults (3). Antidepressants may be indicated for children and adolescents with non-rapid-cycling bipolar depression, psychotic depression, and depression with symptoms that are unresponsive or preclude the use of psychotherapy. Selective serotonin reuptake inhibitors are recommended because of their safety, side effects profile, ease of administration and suitability for long-term treatment. However, pharmacotherapy cannot be used alone because even with a stabilization of the patient's mood, the environmental and social problems remain. Parents should also be counseled to effectively manage their child's problems, and if indicated, parents should be offered treatment themselves (3).

Lynda presents with a complex case exhibiting many of the risk factors and complications of childhood MDD. Since her family has refused medication, it is especially important that she receive adequate counseling along with their support to overcome her illness. Continued research into the treatment of childhood depression is important, especially as the medical community continues to recognize depression earlier in children.

References

1. Pfeffer CR. "Childhood Suicidal Behavior: A Developmental Perspective." *Psychiatric Clinics of North America*. 1997 Sept; 20(3):551-62.
2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition*. Washington, DC. American Psychiatric Association, 2000.
3. "Practice Parameters for the Assessment and Treatment of Children and Adolescents With Depressive Disorders." *Journal of the American Academy of Child and Adolescent Psychiatry*. 1998 Oct; 37(10 Supplement):63S-83S.
4. Volkmar FR. "Childhood and Adolescent Psychosis: A Review of the Past 10 Years." *Journal of the American Academy of Child and Adolescent Psychiatry*. 1996; 35:843-51.

5. Andreasen NC and DW Black. Introductory Textbook of Psychiatry, 2nd Edition. Washington, DC. American Psychiatric Press, Inc., 1995.