

Low mood and depression in adolescence:

clinical update

INTRODUCTION

Low mood (dysthymia) in adolescence (11–19-years-old) is common. Estimates for depressive disorders from UK community-based surveys suggest 10–14% of adolescents have a mental health problem that impacts on function; with anxiety and depression being the leading conditions.¹ Prevalence of a diagnosed depressive disorder is reported to lie between 1–6%.²

The term 'depression', used both as a diagnostic category and also as a subjective description of mood, can be considered to cluster around changes in mood, thinking, and activity levels.

Estimates of recovery suggest 10% of children and young people with depression improve spontaneously within 3 months but the condition is often both recurrent and persistent with 50% still depressed 12 months later.³ Gender differences post-puberty result in more young women reporting low mood, with young people living in disadvantaged households experiencing higher general psychological morbidity.

PRESENTATION

Low mood in teenagers often presents with irritability and disruptive behavioural disorders, such as school refusal or offending behaviour, that may in turn be associated with substance abuse or a history of sexual abuse (see Box 1). Anxiety is a common comorbid state and present, if looked for, in almost all cases of behavioural disturbances.³ Primary care presentations of low mood may well present as 'unexplained physical symptoms (not unlike the adult population); musculoskeletal problems predominate and are significantly associated with depression'.²

Self-harm and depression in adolescence are also associated. While not all young people who self-harm are depressed, a coexisting low mood makes repetition of self-injurious behaviour more likely; as does a history of sexual abuse, exposure to

self-harm (including social transmission or 'the contagion effect'), and concerns about sexual orientation.⁴

In addition, depression in younger patients can present with sleep disturbances, lethargy, apathy; changes in appetite and weight; poor motivation and concentration which impact on performance and can compound feelings of low self-esteem. Social behaviour, both in real-life settings and in cyberspace, changes with a concomitant low mood, and teenagers may withdraw from usual social interactions, isolating themselves from family and friends.

However a common pitfall is to miss an enduring low mood when not all of the above are present. Young people often retain good levels of function in some domains but not others, such as continuing to socialise with friends or to perform well on the football field; at the same time their school work or familial relationships may deteriorate. A mixed picture requires active review.

IDENTIFICATION

Identification of low mood and depression in adolescence can be problematic.

Although internationally agreed diagnostic criteria for depression in adolescence are considered to be the same as for adults, irritability is much more likely to be a prominent feature.² Another critical difference in adolescence, when compared with adult populations, is the frequency of comorbidity of psychological problems. This complicates diagnosis both for primary

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Box 1. Red flag features of low mood in adolescence

- Reduced school or professional performance.
- Social isolation.
- Aggressive, violent behaviour.
- Repeat consultations for ill-defined complaints.
- Family conflict.

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and secondary care practitioners and is in part a result of the unique developmental changes that occur during adolescence.

Questionnaires validated both in community and clinical settings, for example, the Mood and Feelings Questionnaire (MFQ) [<http://devepi.duhs.duke.edu/mfq.html>] are routinely used by Child and Adolescent Mental Health Services (CAMHS) colleagues but not in primary care. They are time intensive to conduct and accrue no QOF payments.

MANAGEMENT

The 2005 NICE guidelines on depression in children and young people remain the cornerstone for evidence-based treatment and advocate a stepped-care model with psychological therapies as the mainstay of treatment.³ While increasing access for psychological therapies (IAPT) for younger patients has been a welcome development it has not increased the capacity of CAMHS teams or the availability of psychological therapy, unlike the model developed for adult services. This means that many of the young people who present in surgery will not be able to access psychological therapy.

Non-specific psychosocial strategies offered in primary care are reported as addressing a need that cannot be met by secondary care,⁵ although they must be subject to rigorous evaluation. Simple brief behavioural interventions include advising about sleep, diet, recommending regular exercise, harm minimisation with regard to smoking and substance abuse, suggesting healthy ways of managing stress, and the importance of cultivating supportive, affirming relationships.⁵

The existing evidence base supports cognitive behavioural therapy (CBT) and interpersonal therapy for mild-moderate depression. New developments include the successful use of mobile phone delivery of a depression intervention derived from CBT using automated text, video, and cartoon images.⁶ Computerised self-help interventions are also being trialled, both to address the gap in accessing psychological therapies and to capitalise on teenagers as 'digital natives'.

Existing guidelines do not support the use of antidepressants in under 18-year-olds in primary care.

PREVENTION: NEW DEVELOPMENTS

Current developments cluster around preventing new episodes of adolescent depression and identifying high risk or vulnerable subgroups. This direction of travel is in part influenced by advances

in neuroimaging and an increasing understanding of the region-specific and non-linear development of the adolescent brain. The prolonged period of plasticity, during which the brain undergoes a synaptic remodelling until cognitive maturation is considered to be complete, is now thought to extend well into the 20s. Maturation of the prefrontal cortex (determining executive functions including problem solving, planning, emotional regulation, and multitasking) lags behind the limbic system (governing reward processing, appetite, and pleasure seeking), creating a developmental imbalance.⁷ This has obvious implications for health behaviour and increases risks for vulnerable teenagers.

In parallel, there is a greater understanding of the complexity of puberty, a biologically-driven process that impacts on behaviour, emotional wellbeing, and health creating 'a period of particular neurodevelopmental vulnerability with increased risk of emotional disorders and risk-taking behaviour'.⁴

This is not the case for the majority of adolescents who emerge into young adulthood prepared for the challenges ahead. Therefore, focusing attention on the subgroup of young people who are at increased risk of developing depression is at the centre of current research. Three high-risk groups have been identified as: those whose parents have a history of depression; those who present with features of low mood but are below the threshold for a depressive disorder; and those adolescents who have already experienced depression, since recurrence rates are high.² It is likely that prevention strategies will remain a key area of activity in the future, along with goals of earlier identification and intervention.

Provenance

Freely submitted; externally peer reviewed.

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