

The Unhappy Teenager

Dr Karen Magraith

On 31 March, at Moorilla, GP South hosted a presentation on The Unhappy Teenager. The speakers were Dr Fiona Wagg, psychiatrist and Dr Anna Brook, clinical psychologist, both from Clare House.

The audience consisted of GPs, psychologists, social workers, mental health nurses and others involved with the care of adolescents. For those GPs who couldn't attend I have summarised some of the points that I took away from the meeting.

Fiona Wagg spoke about the diagnosis of depression. It is well known that many teenagers experience intense feelings, and display behaviours which can indicate significant distress. It can be tricky to distinguish between these normal symptoms and true depression. This distinction is important when it comes to management.

Some of the factors more likely to be seen in major depression include:

- a distinct change in mood and behaviour from that previously seen
- persistently low mood (in unhappiness or 'stress' the teenager is likely to be up and down in response to daily events)
- social withdrawal, friendship problems, significant problems at school
- melancholic symptoms (eg early morning wakening, diurnal mood variation, reduced appetite)
- depressive ruminations (hopelessness, worthlessness, guilt)
- suicidality

As part of the assessment of a depressed teenager it is important to check for anxiety symptoms, obsessive compulsive symptoms, and psychotic symptoms. Psychotic depression in teenagers is associated with a high risk of bipolar disorder. Also consider whether this could be a prodrome of a developing psychotic episode.

This is also the age where personality difficulties can emerge, and may manifest as intense rapidly changing moods, anger, unstable relationship, self harm and risk taking behaviours.

It is important to ascertain a history of substance use including alcohol and cannabis. These need to be tackled before using medications for depression.

Assessment of suicide risk was a key part of the presentation. Teenagers need to know that it's OK to talk about it. It can be helpful to use a graded approach to questions, using questions like 'sometimes young people tell me they wish they could get away from everyone. Have you ever felt like that?' Then gradually become more specific about suicidal ideation and plans.

Treatment: First, back to basics with attention to sleep, diet, exercise and leisure activities. Continued engagement at school and with other activities should be encouraged.

It was useful to me to hear that medication with SSRIs does play a part in the treatment of teenagers with depression. It is indicated when the diagnosis is major depression with melancholia, or when there is significant co-morbid anxiety. The best evidence is for

fluoxetine 20mg daily. There is no evidence that medication helps in self harm, personality disorders, and children. Remember the risk of precipitating hypomania/mania in predisposed patients (check family history).

Dr Wagg recommends starting fluoxetine at 10mg/day for 2 weeks, and increasing to 20mg if tolerated. Remember to review within 2 weeks. The most significant adverse effect is agitation.

The management of suicidality involves short term actions to lower the risk of suicide, and longer term plans to address underlying difficulties. The young person is asked to take responsibility for keeping themselves safe, and letting the appropriate people know if they are feeling overwhelmed by suicidal feelings.

Dr Anna Brook spoke about the role of psychological treatments for adolescent depression.

Research evidence in this area is relatively poor. There is some evidence for the efficacy of CBT, and a study showing that CBT plus fluoxetine is better than either alone. An important part of CBT is behavioural activation. Activities most helpful in shifting depression are enjoyable activities (eg sport, spending time with friends), and achievement activities (eg finishing homework), which improve self esteem. Interpersonal therapy has also been shown to help.

Dysthymia or mild depression can be managed in general practice, but with increasing severity of depression a psychologist, mental health service and/or psychiatrist should be involved.

Wherever possible, parents/carers should be involved in care. However, this may not be possible or needs to be limited if they are abusive, overly critical, or have mental health or alcohol or drug problems.

All practitioners can provide non-directive support to depressed adolescents. The limits of confidentiality should always be explained. Active listening and a non-judgmental stance are important. Notice and comment on strengths, and explore previous coping strategies (eg: 'Tell me about another time you had a problem and how you solved it'.) Always treat the teenager as responsible and capable of contributing to decisions.

After the main presentations we also had short introductions to other services:

- Alcohol and Drug Service (referral form on GP South website). Counselling, treatment groups. Can arrange inpatient withdrawal.
- PULSE - Youth Health service at Glenorchy with multidisciplinary team. Ages 12-24. Health promotion, prevention, early intervention.
- LINK - similar service in city
- Integrated Care Service, run by Relationships Australia. Can take referrals via a Mental Health Treatment Plan.

The evening was packed with information and helped provide a framework for the approach to diagnosis and management of depression in teenagers.