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Managing depression in Children and Young people

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Managing depression in young people.

- **Key learning points**
- How to identify the signs and symptoms of depression in children and adolescents
- Treatment options for young people experiencing depression
- The Nurse (primary care/Health Visitors/School Nurse) role in supporting young people experiencing depression

How to identify young people who have depression – the signs and symptoms

Adolescence is often viewed as a time of “emotional turmoil” and it is normal for most young people to experience occasional periods of sadness and despondency (table 1: myths about depression). However, the experience of clinical depression is very different. In order to receive a diagnosis of depression, the young person has to meet certain criteria. Depression is one of the common mental health problems in children and young people, although it is uncommon in pre-pubertal children with prevalence rates of between 1-2%¹. The overall lifetime and 12 month prevalence of major depressive disorder (MDD) for adolescents aged 13 to 18 is 11.0% and 7.5% respectively. The corresponding rates for severe depressive disorder is 3.0% and 2.3%²; however, depressive symptoms are much more common - up to 29% of adolescents experience depressive symptoms and these are also associated with impairment and suicidality³. Rates of depression differ between boys and girls and the marked rise in depression in older children has been attributed to the increasing prevalence of depression in adolescent girls, a sex difference that persists into adulthood⁴. For a diagnosis of depression the young person must fulfil at least five of the nine symptoms in addition to impairment in functioning. One of the core symptoms must be present at all times: low mood, irritability, or marked diminished interest or pleasure in almost all activities (table 2). The symptoms of depression cannot be attributed to only the effects of substance misuse, medication, a general medical condition or bereavement.

Table 1: Myths about Depression in Children and Adolescents

Myth	Fact
Depression/moodiness is normal in teenagers	Persistent low mood is not normal. They can't just “snap out of it”. Not “just the hormones”
Children and Adolescents are mini adults	Child/adolescent depression is different to adult depression
Discussing depression/suicidality with children and adolescents may make things worse	There is no evidence that discussing depression/suicidality will increase suicidal behaviour. Often a relief.
It is important that parents should continue to strictly enforce behavioural consequences with depressed children and adolescents.	Overly strict parenting not helpful can further lower self-esteem. Depressed children and adolescents will struggle with school/activities; “choose your battles”. Need to support and encourage with appropriate boundaries.
Antidepressants are unsuitable for teenagers	Antidepressants can be useful in moderate to severe depression in adolescents but rarely first line (especially in children)

Although there are significant differences, the core symptoms of depression in both children and adolescents are similar to those seen in adults ⁵. However, depression in young people is associated with increased suicidality and worse outcomes than in adult onset depression.⁶ The clinical presentation is dependent on developmental stage: for example, younger children may present with somatic symptoms such as tummy aches, headaches as well as behavioural changes such as refusing to go to school and separation anxiety ⁷, whereas older children may present as being “bored”, irritable and oversleeping, and demonstrate significantly more hopelessness and helplessness, lack of energy, weight loss and suicidality (table 3)

Table 2: DSM-5 criteria for depression⁸

Major depressive episode (adult)*	Provision for children and adolescents
Depressed mood increased	persistent sad or irritable mood, Irritability, anger or hostility
Loss of interest or pleasure	
Significant weight loss or reduction in appetite	more than 5% of body weight or failure to make expected weight gain) Frequent vague, non-specific physical complaints.
Insomnia or Hypersomnia	
Psychomotor agitation or retardation	
Fatigue or lack of energy	Frequent absences from school or poor School performance
Feelings of worthlessness or guilt	
Decreased concentration	Being bored
Recurrent thoughts of suicide or death	Reckless behaviour, alcohol or substance Misuse
*diagnosis requires 5 or more symptoms, including either depressed mood or decreased interest /pleasure in activities during the past 2 weeks.	

Table 3: “Red flags for depression across childhood⁹

Symptom	6 years	6-12 years	Adolescents
Somatic	failure to thrive Sleep/eating problems	Headaches, tummy aches Sleep/appetite changes	Headaches,tummy aches sleep and appetite changes
Behavioural	Disruptive behaviour Social withdrawal Reduced enjoyment (observed)	Irritability, boredom, apathy fatigue, decreased enjoyment (observed or self-reported)	Apathy, boredom, social isolation increased sexual activity, aggression, self-injurious behaviours
Developmental	Developmental delay or regression	Decreased ability to concentrate at school	Decreased ability to concentrate at school, decreased academic performance.

Impact of depression on young people and their families

Children and adolescents who have had one episode of depression are at future risk of a further episode with continuation into adulthood, and poor psychosocial functioning¹⁰. In clinical samples the risk of further episodes is between 50-70%¹¹. If not managed, depression can lead to a number of complications and may have a profound impact on the young person and their families. Children who experience depression face a range of negative outcomes including school refusal, academic failure, impaired peer relationships, family relationship problems, drug and alcohol misuse in addition to other risky behaviour including under/overeating, smoking, underactivity and unprotected sex.¹²

Table 4: Psychosocial risk factors for depression

- Being female
- Parental depression
- Past history of depression
- Life events
- Family discord
- Authoritarian parenting
- Adversity and trauma
- Drug and alcohol misuse
- smoking
- Medical problems
- Poor sleep
- Bullying
- Deprivation
- LGBT youth
- Academic demands
- Symptoms of borderline personality disorder

Table 5: Mental health resilience in adolescent offspring of parents with depression¹³:

<ul style="list-style-type: none">• Main parent positive expressed emotion• Co-parent support• Good quality social relationships• Self-efficacy• Frequent exercise
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Management of adolescent depression

Depression in adolescence is complex and often presents with other mental health conditions such as anxiety or conduct disorders. The presence of comorbid disorders generally indicates a poorer outcome in relation to suicidality, duration of depression, risk of recurrence and impairment. Depression in childhood and adolescence is a serious illness which requires immediate professional evidence-based treatment. Initially for mild depression, NICE¹⁴ recommends “watchful waiting” for a period of up to four weeks as a first line approach. If this is unsuccessful, non-directive supportive therapy, guided self-help or group CBT should be offered. In cases of moderate to severe depression a psychological therapy should be offered. NICE¹⁴ recommend individual cognitive behaviour therapy (CBT), interpersonal therapy, family therapy or psychodynamic psychotherapy as evidence-based psychological approaches in the treatment of moderate to severe depression. However, there is limited evidence to suggest that one type of psychological therapy is better than another. A recent trial investigating treatment outcomes in depressed adolescents found no evidence to demonstrate the superiority of CBT or short-term psychoanalytical therapy when compared to a brief psychosocial intervention.¹⁵ In relation to antidepressants, Fluoxetine in combination with a psychological treatment is recommended by NICE as a first-line step in pharmacological management.

One of the most worrying complications of depression is its association with suicidality². Mood disorders are a leading cause of suicide in young people¹⁶, therefore it is essential that assessment and treatment take places in a timely and efficient manner¹⁴. Primary healthcare professionals have a key role in the assessment, detection and management of depression in children and young people (table 6). NICE¹⁴ recommend that primary care professionals should have the training and knowledge to recognise children and adolescents who may be at risk of depression, in addition to recognising known factors which are associated with a high risk of depression such as homelessness, refugee status and living in institutional settings. In addition to psychosocial risk factors (table 4) there are also a number of known protective/resilience factors (table 5).

Table 6: Some useful probes for depressed mood

- Have you ever felt sad, blue, down, or empty?
- Did you feel like crying? When?
- Did you have any other bad feelings?
- Did you have a bad feeling all the time that you couldn't get rid of?
- Did you feel () all the time, some of the time?
- Did it come and go?
- How often? Every day?
- How long did it last? What do you think brought it on?
- Could other people tell when you were sad?
- How could they tell?
- Did you look different?

The nurse's role in supporting young people

NICE recommend that Child and Adolescent Mental Health Services (CAMHS) should work with primary healthcare professionals to develop systems for detecting, assessing and supporting children and adolescents who are depressed. The report of the Children and young people's mental health task force¹⁷ recommends greater system co-ordination with a focus on liaison between schools and primary care. Depression in childhood and adolescence is an important public health problem and the Future In Mind transformation plans view early prevention as paramount in order to meet the mental health needs of children and young people. Given both the serious and far reaching consequences of childhood and adolescent onset depression, there is an urgent need to improve both the screening and treatment of this population in the early stages of the disorder² to ensure the best possible outcomes.

The role of the primary care nurse is vital in the early detection and management of children and young people who are depressed. The primary care nurse could potentially be the first point of contact when a parent, education or social care professional is concerned about a young person's mental health. Due to the high prevalence rates within the community of young people with depressive symptoms, primary care nurses are likely to come across such young people and will need to be equipped with the relevant skills in detection, assessment and management. However, due to the heterogeneity of presentations in depressed children and adolescence, healthcare professionals, particularly in primary care settings, may struggle to recognise depression (NICE)¹⁴, therefore it is important that possible symptoms of depression are assessed thoroughly and not overlooked. Primary care nurses should, in collaboration with the young person and their families, refer to a GP and consider a referral to specialist CAMHS for a comprehensive assessment if a child or young person is either not responding to NICE recommended initial interventions, or refer urgently if they have a moderate to severe depressive disorder with suicidal thoughts and/or self-

harm. A recent longitudinal study demonstrated the importance of early referral to CAMHS. In this study, at age 14 adolescents with depressive disorder who had contact with CAMHS had a greater decrease in depressive symptoms when compared to those who had no contact; by age 17 those who had no contact were seven more times likely to report depressive symptoms than those who had contact.¹⁸ The findings of the study demonstrate the importance of early specialist referral and intervention.

There are a number of screening instruments available, but there is limited consensus regarding their use¹⁹. However, research evidence has demonstrated that if the young person answers “yes” to the following questions, this could be as effective as a screening tool: “Over the past two weeks, have you felt down, depressed, or hopeless?” “Have you felt little interest or pleasure in ever doing things?”⁹

The treatment of parental depression is also vital in the management of child and adolescent depression, and support for a parent may also need to be considered. A study which examined interventions to prevent depression demonstrated that treatment of parental depression was one of the most important factors in the prevention of depressive episodes in offspring.²⁰ In addition; treatment of maternal depression is also associated with a significant improvement in the child’s depression²⁰. However; multiple protective factors (table 5) are also required to substantially reduce the risk of mental health problems in children of depressed parents (zero or one protective factor, 4% sustained good mental health; two protective factors, 10%; three protective factors, 13%, four protective factors, 38%; five protective factors, 48%).¹³

The primary care nurse should be aware of what self-help services and resources are available locally to support a young person with depression, such as information leaflets and online resources, helplines and family support groups.

Conclusion

Depression is a common mental health problem in young people. Contact with a primary care nurse offers important opportunities (Table 7) for early intervention to help improve their lives and avoid some of the serious, long-term consequences of this disorder.

Table 7: “First Aid “- Brief psychosocial intervention¹⁵

- ‘formulation’ (understanding of triggers, risk and protective factors)
- Confidentiality (with an understanding that risks must be shared)
- Psycho-education (information about depression and what helps)
- Optimistic reassurance and convey expertise
- Realistic expectations
- Manage contexts: identify and address risks.
- Liaison e.g. with schools, social care, voluntary organisations, paediatrics
- Problem solving
- Family support
- “**Emotional first aid**”, e.g. sleep hygiene, behavioural activation, praise, expressing thoughts and feelings.

References:

1. Angold A, Costello EJ. Epidemiology of depression in children and adolescents. In: Goodyer I (ed). *The depressed child and adolescent*, 2nd ed. Cambridge: Cambridge University Press, 2001:143-78.
2. Avenevoli S, Swendsen J, He J-P, Burstein M, Merikangas K. Major Depression in the National Comorbidity Survey - Adolescent Supplement: Prevalence, Correlates, and Treatment. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2015;54(1):37-44.e2. doi:10.1016/j.jaac.2014.10.010.
3. Balázs J, Miklósi M, Keresztény Á, Hoven CW, Carli V, Wasserman C, et al. Adolescent subthreshold-depression and anxiety: psychopathology, functional impairment and increased suicide risk. *Journal of Child Psychology and Psychiatry*. 2013;54(6):670-7
4. Collishaw (2015). Annual Research Review: secular trends in child and adolescent mental health. *J.Child Psychol Psych*, 56,370-93.
5. Kaufman. J., Martin, A., King, R.A., & Charney, D. (2001). Are child-adolescent, and adult onset depression one of the same disorder? *Biological Psychiatry*, 49, 980-1001.
6. Zisook S, Lesser I, Stewart JW, Wisniewski SR, Balasubramani GK, Fava M, et al. Effect of Age at Onset on the Course of Major Depressive Disorder. *Am J Psychiatry*. 2007;164(10):1539-46
7. Yorbik.O, Birmaher, B, Axelson D, Williamson, DE,Ryan ND (2004) Clinical characteristics of depressive symptoms in children and adolescents with major depressive disorder. *J. Clin Psychiatry*, Dec, 65 (12):1654-9.
8. *Diagnostic and Statistical Manual of Mental Disorders, Fifth edition TR* (2013) American Psychiatric Association.
9. Chung P., & Soares N.S; *Childhood Depression: Recognition and Management; Consultant for Pediatricians*, 2012; 2012; 11:259-267.
10. McLeod G, Horwood L, Fergusson D. Adolescent depression, adult mental health and psychosocial outcomes at 30 and 35 years. *Psychological Medicine*. 2016;46(7):1401-12.
11. Dunn. V., & Goodyer, I.A. (2006). Longitudinal investigation into childhood and adolescence-onset depression: Psychiatric outcome in early adulthood. *British Journal of Psychiatry*,188,216-222.
12. Thaper, A., Collishaw,S., Pine, D.S., & Thaper, A.K. (2012). Depression in adolescence. *Lancet*,379,1056-1067.
13. Collishaw S, Hammerton G, Mahedy L, Sellers R, Owen MJ,Craddock N., et al. Mental health resilience in the adolescent offspring of parents with depression: A prospective Longitudinal study. *The Lancet Psychiatry*. 2016;3(1):49-57.

14. National Institute for Health and Care Excellence. Depression in children and young people: identification and management in primary, community and secondary care (Clinical guideline 28.) 2015. www.nice.org.uk/guidance/cg28
15. Goodyear, I.M, Reynolds, S, Barrett, B, Byford, S, Dubicka, B, Hill, J, Holland, F, Kelvin, R, Midgley, N, Roberts, C, Senior, R, Target, M, Widmer, B, Wilkinson, P, Fonagy, P (2016). Cognitive behavioural therapy and short-term-psychoanalytical psychotherapy versus a brief psychosocial intervention in adolescents with unipolar major depressive disorder (IMPACT) : a multicentre, pragmatic, observer-blind, randomised controlled superiority trial. The Lancet. Published online November 30th 2016. [http://dx.doi.org/10.1016/s2215-0366\(16\)30378-9](http://dx.doi.org/10.1016/s2215-0366(16)30378-9).
16. Windfuhr, K., While, D., Hunt, I., Turnbull, P., Lowe, R., Burns, J., et al. (2008). Suicide in juveniles and adolescents in the United Kingdom. Journal of Psychology and Psychiatry, 49(11), 1155-1165. doi:10.1080/09638230802287411
17. Future in Mind (2015): Promoting, protecting and improving our young people's mental wellbeing. Department of Health.
18. Neufeld, S, Dunn, V, Jones, B, Croudace, J, Goodyer, I (2017). Reduction in adolescent depression after contact with mental health services: a longitudinal cohort study in the UK. The Lancet. Published online January 10th 2017. [http://dx.doi.org/10.1016/S2215-0366\(17\)30002-0](http://dx.doi.org/10.1016/S2215-0366(17)30002-0)
19. Simmons M, Wilkinson P, Dubicka B. Measurement Issues: Depression measures in children and adolescents. Child and Adolescent Mental Health. 2015; 20(4):230-41.
20. Brent DA, Brunwasser SM, Hollon SD, et al. Effect of cognitive-behavioural prevention program on depression 6 years after implementation among at-risk adolescents: a randomized clinical trial. JAMA Psychiatry 2016;72:1110-18.

Resources

<https://www.minded.org.uk/>

<http://www.youngminds.org.uk/> - Young minds

<http://www.youngminds.org.uk/noharmdone> - films re self-harm

<http://www.rcpsych.ac.uk/> - Royal college of Psychiatrists

<http://www.cwmt.org.uk/> also provide training