Adolescent Depression

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Depression

Every year, approximately 50 in 1,000 adolescents experience the torment of major depression.¹ Periods of anxiety or depression during adolescence are common and can be normal reactions to life events.² But, there is a difference between simply feeling depressed over a life event and clinical depression. Clinical depression involves overwhelming feelings of being sad for weeks or longer.³ According to the Center for Mental Health Services, 12.5 percent of teens endure clinical depression.⁴ The mental-health ailments suffered by many adolescents are being overlooked by busy, distracted, or uninformed adults.⁵

Among adolescents, aged 12 to 17 who reported having suffered a major depressive episode (MDE) in 2004, only 40.3 percent received depression treatment within that time period.⁶ Depressed teenagers are often “misdiagnosed, underdiagnosed, and undertreated.”⁷ Population studies show that at any given instance between 10 and 15 percent of the child and adolescent population endures symptoms of depression.⁸ Predictions indicate that depression may be the second largest killer after heart disease by the year 2020, and epidemiological studies show that depression is a contributory factor to fatal coronary disease.⁹

The mood disorders that are most often diagnosed in adolescents are major depressive disorder, dysthymic disorder, and bipolar disorder.¹⁰ The condition of major depressive disorder is a dire illness identified by at least one MDE.¹¹ About 2.2 million adolescents ages 12 to 17 (9 percent) languished at least one MDE in 2004.¹² A teen with at least five signs or symptoms of depression during a two-week period is having a MDE. The symptoms of a MDE include a depressed or irritable mood; diminished interest in almost all activities; sleep disturbance; appetite disturbance; decreased concentration; thoughts of suicide or death; psychomotor agitation or retardation; fatigue; and feelings of worthlessness or inappropriate guilt.¹³ Behaviors associated with a MDE include the following: substance abuse (self medicating), eating disorders (such as anorexia), self injury (such as cutting), and acting out (such as aggression).¹⁴ Once a young person has experienced a major depression, he or she is at risk of having a recurrence within five years.¹⁵
Dysthymic disorder is a mood disorder like major depressive disorder, but it has fewer symptoms and is more chronic. Bipolar disorder is a mood disorder in which episodes of mania alternate with episodes of depression. The disorder normally begins with depression and the first manic features may not occur for months or years after the first depressive episode. Manic symptoms include difficulty sleeping; incessant talking, often rapidly or loudly; and racing thoughts. Manic adolescents may start numerous projects without finishing them; engage in reckless or risky behavior; or become overconfident in their abilities. Twenty to 40 percent of adolescents with depression eventually develop bipolar disorder. Reactive depression is the most common mood problem in adolescents in reaction to minor adversities, which is not considered a mood disorder.

Some of the core symptoms of depression, such as changes in appetite and sleep patterns are related to the functions of the hypothalamus. The hypothalamus is, in turn, closely tied to the pituitary gland. Abnormalities of pituitary function, such as increased rates of circulating cortisol and hypo- or hyperthyroidism, are well-established features of depression.

The 2004 annual National Survey on Drug Use and Health showed that very depressed youth aged 12 to 17 were twice more likely to engage in substance abuse than those who were not depressed. About 28 percent of depressed teens used alcohol, 23 percent smoked cigarettes, and roughly, 21 percent used drugs.

Strategies need to be instituted to reduce the stigma attributed to mental illness and obtain treatment for those afflicted. Upon diagnosis, there are various treatment options for the depressed individual. Medication was once the first treatment option, but is not currently the preferred method. Studies indicate that antidepressants only work in 35 to 45 percent of the population. The U.S. Food and Drug Administration (FDA) issued a public-health advisory in October of 2004 forcing manufacturers of antidepressant drugs to display a warning to alert medical professionals to the greater risk of suicidal thinking and behavior in children and adolescents being given these medications.

Since medications are questionable, the most viable option would be to address the underlying causes of depression instead of just the symptoms. The other treatments for depression involve therapy. The therapeutic treatments include the following: cognitive-behavioral therapy, group therapy, family therapy, and psychodynamic psychotherapy. Cognitive-Behavioral therapy is based on the idea that emotions are a learned response, the psychological pain is due to a person's perception of what events mean to him/her. The goal of cognitive-behavioral therapy is overturning pessimistic ways of thinking, creating social skills, and setting goals to pursue pleasurable activities via patient-therapist discussions. Group therapy involves
breaking down the feeling of isolation in the depressed adolescent, which can alleviate some of the depressive symptoms by realizing they are not alone in their experiences. Family therapy addresses patterns of communication in the family and attempts to restructure the family in order to provide a better support base for the patient. Psychodynamic psychotherapy attempts to link symptoms of depression to childhood traumas or conflicts. Early traumatic experiences such as abuse or incest can manifest as depression; these suppressed memories can emerge in adolescence.

The simplest method for alleviating depression may be physical exercise. Exercise causes the brain’s chemistry to create more endorphins and serotonin, which change mood.

**Suicide**

*Suicide is a permanent solution to a temporary problem* (Phil Donahue).

Over 90 percent of adolescents with suicidal tendencies have a treatable psychiatric disorder. Mood disorders are major risk factors for suicide among children and adolescents. Up to 15 percent of individuals diagnosed with major depressive disorder die by suicide. An reported 11 in 100,000 youth between the ages 15 to 19 will attempt suicide each year and many more suicide attempts will go unreported. The third leading cause of death in 2002 was suicide in the 15 to 24 age group; the first and second leading causes of death were accidents and homicides, respectively. Some accidents may actually be suicides in disguise. Teen females attempt suicide more frequently (about nine times more often) than teen males, but males are about four times more likely to succeed when they are trying to kill themselves. This is because teen males tend to use more deadly methods (like guns or hanging) than females who try to hurt or kill themselves with less deadly methods (like overdoses of medications or cutting). In 2002, an estimated 124,409 visits to U.S. emergency departments were made after attempted suicides or other self-harm incidents among persons aged 10-24 years. The most frequent method of suicide in this age group was by firearm (49%), followed by suffocation (38%), and poisoning (7%).

The suicide risk among people with depression is about 30 times higher than that of the general population. “Four psychosocial factors were found to be important for overall suicide risk: hopelessness, hostility, negative self-concept, and isolation.” Suicide can emanate from a depressed person’s feeling that life is so intolerable that death appears to be the sole deliverance; the suicidal individual sees no opportunity for change or improvement. The suicidal individual cannot see beyond his/her depressive state symptoms. “In suicidal individuals dysregulation of the serotenogenic system is common, making them impulsive, intense, and given to extreme reactions.” A hazardous period in depression occurs when an individual is coming out of the deepest part
of the experience and utilizes their newly acquired energy to take their own life.\textsuperscript{44} It is not uncommon for an individual to appear joyful prior to committing suicide.

The following behaviors are common to someone who is suicidal:
- Preoccupation with death;
- Statements of low self esteem;
- A setting of affairs, such as possession of a will;
- Giving away cherished possessions;
- Suicidal ideation;
- Suicidal threats; or
- Suicidal-plan possession.\textsuperscript{45}

**Nevada**
According to the 2005 Youth Risk Behavior Survey (YRBS), 27.8 percent of Nevada high school students felt so sad or hopeless almost every day for 2 or more weeks in a row that they stopped doing some usual activities.\textsuperscript{46} In the past 12 months, 16.1 percent of Nevada high school students seriously considered attempting suicide.\textsuperscript{47} Close to nine percent of Nevada high school students attempted suicide one or more times.\textsuperscript{48} In 2004, 19 percent of teen violent deaths (ages 15-19) were by suicide. Accidents were 61 percent and homicides were 20 percent.\textsuperscript{49}

**Conclusion**
The condition of clinical depression involves overwhelming feelings of being sad for weeks or longer. Many adolescents who suffer from clinical depression are unable to escape their dark moods without treatment. The most often diagnosed mood disorder among adolescent is major depressive disorder. Due to the suicide dangers associated with current medications, adolescents being treated by medication need to be monitored carefully. Therapy is preferred over medication, since the FDA warning in 2004. Since the majority of suicides occur among individuals with treatable psychiatric disorders, it is paramount to identify adolescents with these conditions before it is too late. With education and awareness, suicide occurrences can be reduced and perhaps moved down the list of leading deaths.

**References**
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