Depression in children and adolescents can interfere with the developmental trajectory impairing educational experiences and close relationships. In turn, this can have enduring consequences to self confidence, self worth, and capacity to form good relationships.

The secondary effects of depression in children and adolescents can persist into adult life and become risk factors for subsequent depressions, as well as onsets of adult personality disturbances and disorders. In particular there is the much increased risk of self-harm and suicide. There are also substantial economic costs both to the health services and wider society.

Unfortunately, services are not good at detecting depression in children and adolescents as reflected in data provided by NICE (2005) and Garber (2008). Even when we do detect cases, the best treatments we have do not cure all cases (Dubicka et al, 2009; Goodyer et al, 2007; NICE, 2005).

This two-part module focused on highlighting the simple things, with reference to more complex material; the point is that doing the simple things very well and keeping on doing them very well is the foundation upon which we can build services that will improve outcomes for the future.

Epidemiology and care pathways

- Prevalence rates are around 0.5-0.75% for 6–11 year olds. Rates increase with age, reaching 2–4% for 12–18 year olds (NICE, 2005).

- Following the ICD-10 criteria around 50–60% of diagnosed cases fall into the mild category and 40–50% will present with moderate or severe episodes.

- 75% of cases in need of specialist depression services are not being referred.

Recognition and diagnosis

- Detection and referral rates from primary care to specialist care remain very low (due to factors such as stigma or parents/professionals being less good at picking up indicators of depression); not more than 10–12% of all cases. No more than 25% of all cases get any appropriate treatment at any level of service.

- Assessments of children and adolescents are different to adults as there are differences in use of language, that reflect different, less mature levels of thinking, less capacity to self-reflect and verbalise thoughts and feelings.

- Depression as it presents in specialist services is highly comorbid. The most common co-occurring conditions are anxiety disorders, conduct disorders, eating disorders, OCD, ADHD and pervasive development disorders, and substance misuse.

Therapeutic assessment and case management

- ‘Brief psychosocial interventions’ (BPI) of patients and their parents/carers includes the full package of assessment, formulation and case management.

- Case management is achieved by: effectively engaging with the young persons and their parents, accurately diagnosing depression and comorbid conditions, understanding the impairments and consequences of the ‘lived experience’ including effects in other settings such as school or peer relationships, conducting a careful and accurate risk assessment (risk to self, risk to others, risks from others including safeguarding), identifying risk and protective factors in relation to the depression, a psycho-educative process that aims at all points to activate patients, their parents and the social system around patients, and a strategic management plan arising from the assessment.
• The chances of an assessment being therapeutic are enhanced if every opportunity is taken to forge a good engagement and working alliance, the patient and their parent/carers feel they have really been listened to, the treating clinician is able to use their expertise to translate the patient’s distress into something meaningful for the patient and their family, the clinician is able during the assessment to find protective factors and resilience that can be used to counteract the tendency towards depression and illness or risk, and the clinician can begin to suggest active solutions to the dilemmas and problems being presented.

Core psychological issues

• Some core psychological constellations and patterns of presentation in depression in children and adolescents include: impaired problem solving, a tendency to avoid difficult things or even potentially positive experiences by either ruminating and/or withdrawing, leading to impairments across interpersonal situations and/or personal achievements in academic or sporting spheres of life.

• Some patterns of thinking are thought to become established during earlier losses and traumas. These may become reactivated during times of distress and loss later in development, and hence contribute to a negatively self-reinforcing pattern of behaviour that serves to maintain and exacerbate a depressive mood.

• Common categories of risk factors include bullying, parental conflict, disappointment and loss, maltreatment or very traumatic event, family history, substance misuse, and ruminating cognitive style.

Psycho-education

• Effective psycho-education requires the clinician to have expertise in the disorder, including expertise in the underlying science and linked evidence base, how the disorder manifests, the outcomes of the interactions between the patient, their family and their wider social systems with the disorder and a language by which to translate all this for the patient, their family and their wider social systems.

• The clinician will be doing all this within the bounds of consent and confidentiality agreements and all the while looking to build on protective factors, resiliencies whilst counteracting risk factors and the effects of the depression itself.

References


