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Adolescent Anxiety And Depression

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Abstract: The mental health of child, adolescent and youth is probably a continuum from a child development perspective – normal and abnormal, evolution of problems, causative and risk factors and ultimately the outcome. Any retrospective search for cause, is likely to be biased. It is said that many of the adult psychiatric disorders have their onset in adolescence. Mental health issues of adolescents have to be addressed in the primary care set-up itself, because there are far too many children and adolescents with behavioural, emotional and mental health problems in the community and only limited number of psychiatrists, clinical psychologists and trained counsellors are available.

1. INTRODUCTION

In India, trends in adolescent health in priority mental health areas have uniformly been static or adverse, in contrast to gains made in other countries.[1]Hence, what we need in India, is a team approach with a referral line starting with parents/teachers/ community health workers who may suspect a problem, which may be diagnosed and managed at the primary care setting itself. Referral services to higher centres are needed only for a few selected cases, primarily to confirm the diagnosis, rule out co-morbid conditions and chalk out a management strategy, implementation of which can be done by the primary care team, if only they could suspect and diagnose early. We need to remember that although DSM-V/ICD 10 Criteria is the gold standard for diagnosing mental health disorders including anxiety disorders and depression, what is more important, for a primary care physician is to remember that the symptom complex per se do not make a diagnosis, unless it is

(i) more than explainable by the apparent cause

(ii) have significant bodily symptoms and

(iii) symptoms are severe enough to cause impairment in daily functions.

2. ANXIETY DISORDERS

Anxiety disorders are a group of mental health disorders, characterized by excessive feelings of anxiety and fear, the anxiety being worry about future events and fear, a reaction to current events causing physical symptoms such as a racing heart and shakiness. Fear and anxiety are in the same continuum, fear is the reaction to a present danger, an adaptive and evolutionary refined process and anxiety is the response to a potential threat. Anxiety is a

disproportionately intense, chronic and potentially irreversible reaction to an imagined threat, operated through brain-body-emotion-cognitive-changes and their interaction with the environment.[2] The anxiety disorders may be grouped as follows:

Generalized anxiety disorder (GAD): GAD is a common, chronic disorder characterized by long-lasting anxiety that is not focused on any one object or situation. Those suffering from generalized anxiety disorder experience non-specific persistent fear and worry, and become overly concerned with everyday matters. In children GAD may be associated with headache, restlessness, abdominal pain and heart palpitations. Typically it begins around 8 to 9 years of age. If a child has GAD, they may worry about anything, even if it is seemingly minor. They long for attention, approval and encouragement from others.

Phobias: Phobic disorders, includes all cases in which fear and anxiety are triggered by a specific stimulus or situation. Sufferers typically anticipate terrifying consequences from encountering the object of their fear. Sufferers understand that their fear is not proportional to the actual potential danger but still are overwhelmed by the fear. School phobia is a common anxiety disorder in children, which in some cases can be a type of separation anxiety, with no obvious cause. School phobia may also be a form of social phobia, also known as social anxiety.

Panic disorder: With panic disorder, a person suffers from brief attacks of intense terror and apprehension, often marked by trembling, shaking, confusion, dizziness, nausea, and/or difficulty in breathing. These panic attacks are fear or discomfort that abruptly arise and peak in less than ten minutes and can last for several hours. Attacks can be triggered by stress, fear, or even exercise; the specific cause is not always apparent.

Social anxiety disorder (SAD): SAD also known as social phobia describes an intense fear and avoidance of negative public scrutiny, public embarrassment, humiliation, or social interaction.This fear can be specific to particular social situations (such as public speaking) or, more typically, is experienced in most (or all) social interactions.

Obsessive-compulsive disorder (OCD): OCD is a type of anxiety disorder primarily characterized by repetitive obsession (distressing, persistent and intrusive thoughts or images) and compulsion (urges to perform specific acts or rituals).

Post-traumatic stress disorder (PTSD): PTSD is an anxiety disorder that results from a traumatic experience. Adolescents would normally feel upset and anxious with any unusual event, but when there is (i) a history of real or perceived catastrophic trauma like death of parents, (ii) an intrusive recollection of the traumatic event, (iii) with autonomic arousal symptoms like sweating and palpitation and all resulting in, (iv) avoidance of the situation, it is called a post traumatic stress syndrome.

Separation anxiety disorder (SepAD): SepAD is the feeling of excessive and inappropriate levels of anxiety over being separated from a person or place. Separation anxiety is a normal part of development in babies or children, and it is only when this feeling is excessive or inappropriate that it can be considered as a disorder.

Situational anxiety: Situational anxiety is caused by new situations or changing events. It can also be caused by various events that make that particular individual uncomfortable. Often, an individual will experience panic attacks or extreme anxiety in specific situations.Although anxiety disorders are among the most common and functionally impairing mental health disorders to occur in adolescence, there is paucity of comprehensive data on adolescent anxiety disorders in India.[3] Among the juvenile age group globally the reported prevalence of anxiety disorders vary from 6.9% to 27% which is more than the most often seen morbidity of mood disorders (6.4%), disruptive disorders (6.4%) and substance abuse (5.3%).

The reported prevalence of generalized anxiety disorder vary from 0.2 to 5.8%, social anxiety disorder vary 1.6 to 12.8%, panic disorder 0.2% to 10% of those attending child psychiatry clinics and separation anxiety disorder (4.1%).[4] The common symptoms among anxiety disorders in adolescents observed in India are: (i) anxious mood (12.6%), cognitive symptoms (9.9%) and physical symptoms (9.2%). The predominant symptoms among various sub types anxious mood; (i) panic disorder (32%), (ii) generalized anxiety disorder (12.2%), (iii) separation anxiety disorder (5.3%) and social anxiety disorder (1%).[5]

To screen for anxiety disorders among adolescents in primary care settings many self-rating measures exists, a recent meta-analysis has shown that the most commonly used one to evaluate anxiety disorder symptoms is "Screen for Child Anxiety Related Emotional Disorders (SCARED)". SCARED, a self-rated questionnaire has 41 items under the five subscales of panic / somatic, generalized anxiety, separation anxiety, social phobia and school phobia. Adolescents are asked to rate the frequency with which they experience each symptom using a 3 point likert scale (0=almost never, 1=sometimes and 2=often). As against the original cut-off score of 31, a recent community study in Kerala has suggested a cut-off score of 21 for screening anxiety disorders among adolescents with better diagnostic accuracy properties.[6] Depression Historically, children were not considered candidates for depression. Today, childhood depression is widely recognized and health professionals see depression as a serious condition affecting both adolescents and young children.[7] Because adolescents are already moody and unpredictable due to other changes and pressures in their lives, parents must know how to differentiate between the normal struggles of adolescent growth and serious emotional problems. One of the factors that make depression so difficult to diagnose in adolescents is the common behaviour change that are normally associated with the hormonal changes of this period.[8] It has only been in recent years that the medical community has acknowledged childhood depression and viewed it as a condition, which requires intervention.

Self-esteem: One of the chief differences between adult and adolescent depression is that depression in adolescents usually involves more social and interpersonal difficulties, which directly leads to self-esteem problems. The inability to relate positively in social situations may lead to low self-esteem which leads to depression. The depression then leads to further inability to relate with others or be fully accepted in social groups which then adds to the feelings of low self-esteem.[9]

Autonomy: Another factor associated with adolescent depression and negative behaviors is difficulty in establishing autonomy in the adolescent's relationship with parents. Adolescent depression is seen in higher frequency in families where the children have difficulty establishing their own identity because of negative communication patterns and other dysfunctional family attributes.[10]

Suicidal ideation: Adolescents are also more likely to idealize suicide as a solution to feelings of helplessness. Adolescents may also socially isolate themselves when depressed out of feelings of guilt. Dramatic behaviors such as aggression and an obsession or fascination with death often accompany their depression.

Depressive disorders, which include major depressive disorder (unipolar depression), dysthymic disorder (chronic, mild depression), and bipolar disorder (manicdepression), can have far reaching effects on the functioning and adjustment of young people. Among both children and adolescents, depressive disorders confer an increased risk for illness and interpersonal and psychosocial difficulties that persist long after the depressive episode is resolved; in adolescents there is also an increased risk for substance abuse and suicidal behavior.[11,12,13] Diagnosis Symptoms of major depressive disorder common to adults, children and adolescents are:

(i) persistent sad or irritable mood,

(ii) loss of interest in activities once enjoyed,

(iii) significant change in appetite or body weight,

(iv) difficulty in sleeping or oversleeping,

(v) psychomotor agitation or retardation,

(vi) loss of energy,

(vii) feelings of worthlessness or inappropriate guilt,

(viii) difficulty concentrating and

(ix) recurrent thoughts of death or suicide.[14]

Five or more of these symptoms must persist for 2 or more weeks before a diagnosis of major depression is indicated. Depression may often be seen in physical ailments such as digestive problem, sleep disorders or persistent boredom (vegetative symptoms). Lamarine, considers that in children, depression may often be mistaken for other conditions such as attention deficit disorder, aggressiveness, physical illness, sleep and eating disorders and hyperactivity. Although depression in children may be confused with attention deficit hyperactivity disorder (ADHD), ADHD must begin before the age of 7.[15,16] According to Fritz, about 5% of adolescents suffer from depression symptoms such as persistent sadness, falling academic performance and a lack of interest in previously enjoyable tasks. In order to be considered major depression, symptoms such as suicidal thoughts, lack of appetite and loss of interest in social activities must continue for a period of at least two weeks.[17]

Community diagnosis, however usually rely on a formal testing using Beck's depression inventory (BDI) or Children's depression rating scale (Revised). Information provided by collaterals, including parents, teachers and community advisors should also be taken into account. Beck's Depression Inventory (BDI), is a mood measuring device developed by Dr.AaronT.Beck (US). The device detects the presence of depression and accurately rates its severity. The multiple-choice questionnaire has 21 groups of statement. The score ranges from 0 to 3 for each statement. The total score is 63.

The questionnaire is scored by adding up the score for each of the 21 items and obtaining the total. A score 21 and above suggest moderate depression needing individual cognitive behavior therapy and score 31 and above suggest severe depression needing medication in addition to psychotherapy. Management There are two main avenues to treatment: psychotherapy and medication. Often, both may be required. The majority of mild depression in adolescents respond to supportive psychotherapy with active listening, advice and encouragement. Issues of alcohol and substance abuse may have to be addressed by referral to relevant agencies. Formal family therapy may be required to deal with specific problems or issues. Co-morbidity is not unusual in adolescents and possible pathology, including anxiety, obsessive-compulsive disorder, learning disability or attention deficit hyperactive disorder, should be searched for and treated, if present.

For the more serious and persistent depression, particularly those with vegetative symptoms or suicidal ideation, medication is essential and may be life-saving. Adolescents because of the common side effects, including sedation and anti-cholinergic action, generally poorly tolerate traditional antidepressant drugs. This leads to poor compliance. The advent of selective serotonin reuptake inhibitors (SSRIs) has largely put these worries to rest. SSRIs are well tolerated by adolescents because of their fairly rapid action and low tendency to cause side effects.

Low toxicity also makes them particularly helpful in an impulsive patient population. It is important that an adequate time period be given to allow the medication to work (four to six weeks) and that adequate doses are used.

Acute phase: The drug is continued for 4 - 6 weeks. • Always target symptoms desired, the side effects, dose schedule and delayed onset of antidepressant action should be discussed.Look for side effects and if response is inadequate, increase the dose or change the drug.

Continuation phase: Continue the same dose for 6 - 12 months along with psychological methods.

Maintenance: This is to prevent recurrence of depression in the following situations which includes multiple severe episode, family history of bipolar disorder or recurrent depressive disorder, co morbid psychotic symptoms, stressful/ non-supportive environment and residual symptoms.[18]

While the recovery rate from a single episode of major depression in children and adolescents is quite high,[19] episodes are likely to recur.[20] In addition, youth with dysthymic disorder are at risk for developing major depression.[21] Prompt identification and treatment of depression can reduce its duration and severity and associated functional impairment.

In summary, mood disorders, particularly depression, are increasingly being recognized among adolescents. The adolescent may not look depressed always, instead may try to cover-up depression by showing over activity. The pediatrician must ask for evidence of a persistent feeling of (i) worthlessness, (ii) hopelessness, (iii) helplessness, (iv) no future at all and (v) suicidal ideation. In depression, the bio-psycho-social model denotes that there are neurotransmitters involved and hence drug therapy is of prime importance. Cognition or the thought process as such, primarily affects mood and hence the primary defect is in the thought process called cognitive error-over generalization, minimization of positive and maximization of negative attributes, necessitating cognitive behavior therapy by trained clinical psychologists.

The pediatrician must ensure the support of family, teachers and friends to maintain positive results of therapy and consult a psychiatrist, if no response at all after 6 weeks drug therapy, which may be extended for 6 months to one year.

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