UNIT NO. 4

ADOLESCENT MENTAL HEALTH

Dr Geraldine Goh, Prof Kua Ee Heok

ABSTRACT

Adolescence is the time for identity formation, self-determination and a time for appraising the need for exploration versus the responsibility of making a commitment. Disorders in adolescence can be divided into residual childhood problems, problems of/in adolescent transition, and early adult disorders/adult type disorders. Behavioural problems in adolescence can be categorised as disruptive, anxious, moody, developmental deficits, and social deficits. This article covers adolescent depression and frequent issues that adolescents have, such as anger management, coping with failures, confidence and self-esteem.

SFP 2007; 33(4): 32-36

INTRODUCTION

Current epidemiological data suggests that the prevalence of child and adolescent mental disorders is about 20%; and 4 to 6% are in need of clinical intervention for an observed significant mental disorder. A local five-year review of adolescent mental health usage in Singapore (Lee NB et al, SMJ 2003) showed a total of 2,536 new adolescent referrals to the Child Guidance Clinic in the five-year period, with an increase of 33% from 1997 to 2001. Conduct and oppositional disorders (18.4%), stress and adjustment disorders (17%), mood disorders (12.2%) and anxiety disorders (9.5%) made up the majority of diagnosis seen. A study in NUH of suicidal behaviour among young people showed the incidence increased six-fold between 1991 and 1995 (Ho B, Hong C & Kua EH; Gen Hosp Psychiatry 1999).

Adolescence is the time for identity formation, self-determination and a time for appraising the need for exploration versus the responsibility of making a commitment. Symptoms are not always abnormal and behaviours can be adaptive or maladaptive depending on the stage of development.

Mental disorders in adolescence can be divided into:

1. Residual childhood problems
   - pervasive developmental disorder, language & learning disorders, mental deficiency, attention deficit hyperactivity disorder, attachment disorder, separation anxiety disorder, oppositional or conduct disorder.
2. Problems of/in adolescent transition
   - anorexia nervosa, parasuicide, deliberate self harm, substance misuse.
3. Early adult disorders/ Adult type disorders
   - bipolar mood disorder, schizophrenia, anxiety disorders, depressive disorders, obsessive compulsive disorder, psychosomatic disorders

Behavioural problems in adolescence can be categorised as:

1. Disruptive
   - hyperactive, aggressive, destructive, oppositional, substance abuse or sexualised behaviours
2. Anxious
   - worry, fearfulness, avoidant behaviour, selective mutism, sleep problems, regressive behaviours, ritualistic behaviours, somatisation
3. Moody
   - irritability, withdrawal, sadness, crying, avoidant or regressive behaviours like acting out, weight and sleep disturbances
4. Developmental deficits
   - deficits in milestones, language and motor skills
5. Social deficits
   - solitary playing or persistent parallel play, shyness or avoidant behaviour, inability to read social cues, inappropriate behaviours or use of language

ADOLESCENT MENTAL HEALTH ISSUES

The issues that have been chosen to be covered here are:

1. Adolescent depression
2. Frequent issues that adolescents have:
   a. anger management
   b. coping with failures
   c. confidence and self-esteem

ADOLESCENT DEPRESSION

The suicide attempt in adolescents with a Depressive Disorder or a Major Depressive Disorder is an inherent possibility that cannot be ignored. However, most adolescent depressions can be managed successfully by the GP with the support of the family, in collaboration with a Child & Adolescent Psychiatrist. About 12% of our attendees at the Child Guidance Clinic have a mood disorder. Despite this fact, depression in this age group is greatly under-diagnosed, leading to serious difficulties in school, work and personal adjustment which often continue into adulthood. Adolescent girls are twice as

GOH SHU CHEN GERALDINE, Associate Consultant, Psychological Medicine, National University Hospital

KUA EE HEOK, Senior Consultant, Psychological Medicine, National University Hospital

likely as boys to experience depression, as anger is more commonly turned inward in girls and outward in boys.

Adolescent depression can be missed

Depression can be a temporary response to many situations and stresses. Adolescence is a time of emotional turmoil, mood lability, gloomy introspection, great drama, and heightened sensitivity. In adolescents, depressed mood is common because of the normal maturation process, the stress associated with it, the influence of changes in sex hormones, and need for independence that often can cumulate to conflicts with parents. Depressive disorder in adolescence is often difficult to diagnose because normal adolescent behaviour is marked by both up and down moods. These moods may alternate over a period of hours or days. Our challenge is to separate the depressive symptoms from the background of transient adolescent emotional turmoil.

Thus, the diagnosis of adolescent depression cannot only rely on a formal clinical interview, but on information provided by parents, school teachers, and counsellors. The identified patient's temperament must also be taken into account and there is a need to identify the triggers, stress, or trauma that may have preceded the clinical state. Therapeutic alliance is the cornerstone of the assessment and treatment in psychiatry; it is even more so with adolescents. Unless trust and rapport are established, the adolescent will not usually readily share his/her feelings with an adult stranger. Confidentiality often needs to be guaranteed, with the exception of the presence of imminent mortal or moral danger. Parents, who are often necessary allies in treatment, should not be made to feel excluded, but to appreciate the value of having their adolescent have at least one person avail to them. Assessment may require more than one interview and the process cannot be rushed. Evaluation of possible suicidal ideation is imperative.

Common symptoms of adolescent depression

Symptoms of in adolescent depression can be and are often atypical compared to these classic symptoms. The following list is not exhaustive:

- Depressed or irritable mood;
- Temper (agitation);
- Loss of interest in activities or reduced pleasure in daily activities;
- Appetite changes (usually a loss of appetite but sometimes an increase) or change in eating habits;
- Weight change (unintentional weight loss or unintentional weight gain);
- Persistent difficulty falling asleep or staying asleep;
- Excessive daytime sleepiness and fatigue;
- Difficulty concentrating;
- Difficulty making decisions;
- Episodes of memory loss;
- Preoccupation with self and feelings of worthlessness, sadness, or self-hatred;
- Excessive or inappropriate feelings of guilt;
- Acting-out behavior (staying out late, unusual defiance);
- Preoccupations in morbid and nihilistic themes (e.g. death and dying, corpses, coffins, decompositions, massacres) may be expressed in writing or art;
- Thoughts or plans about suicide or obsessive fears or worries about death or a disdain towards life and the future;
- Excessively irresponsible behavior pattern.

These symptoms of depression often result in secondary problems at home, in school and socially. At times, it is these problems that draw attention to the depression.

Assessing suicide risk

Young people frequently contemplate issues of mortality and contemplate the effect their death would have on close family and friends. Fortunately, few actually act on these ideas. Suicidal acts are generally associated with a significant acute crisis in the adolescent's life and may also involve concomitant depression. A suicide in a relative or close friend is an important identifier of those at the greatest risk. Those who exhibit obvious personality change – including social withdrawal, or who give away treasured possessions, may also be seriously contemplating ending his/her life.

More adolescents attempt suicide than those actually succeed. Parasuicides are common, and there is a tendency to treat attempts as attention seeking, histrionic, and of no importance. All suicidal behaviours reflect a cry for help and must be taken seriously. An adolescent who has attempted suicide and has not received any relief from his or her impossible situation may well be a successful repeater.

What to do with a depressed adolescent

The management of the depressed teenager begins with building a therapeutic alliance. It is important that the interview is conducted in a relaxed manner, and it may have to be conducted over several sessions before problems can be adequately addressed. The physician needs to be aware of his or her own biases. A depressed adolescent can be oppositional, taunting and retortive even when they have very fragile self-esteem. Projective identification can occur and their feelings of helplessness might be unconsciously experienced by the physician. It is important to accept this behaviour as part of the depression and treat it accordingly.

The involvement of the family is ideal. An evaluation of available support may include family members. School is also important and the adolescent should be provided with resources that are available in crisis.

Treatment of adolescent depression

Psychotherapy is the mainstay of treatment and medication ideally to be considered only if the psychotherapy does not achieve optimal benefits or if the depression is very severe. The majority of mild depressions in adolescents respond to supportive psychotherapy with active listening, advice and encouragement. Issues of alcohol and substance abuse may have to be kept in mind. Formal family therapy may be

required to deal with specific problems or issues. Comorbidity – including anxiety, obsessive-compulsive disorder, learning disability or attention deficit hyperactive disorder – is not uncommon in adolescents, and it should be searched for and treated if present.

When to refer the adolescent to a psychiatrist

Seeing a psychiatrist still sometimes carries a stigma for some, and some find it unacceptable for their children to be seeing one. The role of the primary care physician is vital in the management of adolescent depression. However, referral should be considered under a number of circumstances, namely:

- If the physician cannot engage in conversation with the adolescent because of the adolescent's resistance or the physician's own insecurity about dealing with this age group;
- If the depression is judged to be severe or if there have been some suicidal concerns;
- If the patient's condition does not improve in the expected time, or if there is any deterioration or worsening of the depression despite adequate treatment.

It should be stressed that the majority of adjustment disorders and adolescent depressions can be managed successfully by the primary care physician with the support of the family.

FREQUENT ISSUES THAT ADOLESCENTS HAVE

Anger management, coping with failures, and building confidence and self esteem are hurdles that we have to learn to negotiate, be it successfully or not, for the most part during adolescence. When not dealt with at adolescence, it can lead to psychological and psychiatric problems. When allowed to persist to adulthood, it becomes a liability in the different aspects of life. The following section is written in a way that it comprises sections that can be presented to the adolescent patient.

Anger management

Anger is a completely normal, usually healthy, human emotion, but if we do not understand and control it, it is often destructive. According to psychologist Charles Spielberger, anger is "an emotional state that varies in intensity from mild irritation to intense fury and rage." Like any other emotions, the physiological and biological aspects are neglected. We are programmed to react in order to survive. Anger is a natural, adaptive response to threats.

The three main approaches are expressing, suppressing, and calming.

1. ***Expressing.*** Expressing your angry feelings in an assertive and not aggressive manner is the healthiest way to express anger. The art of learning how to make clear what your needs are, and how to get them met without hurting others, is one that needs to be honed with practice. Take note:
   - Being assertive doesn't mean being pushy or demanding; it means being respectful of yourself and others.
   - Letting your anger rip-out escalates anger and aggression and does nothing to help you (or the person you're angry with) resolve the situation.

2. ***Suppressing.*** Anger can be suppressed, and then converted or redirected into more constructive behaviour. What you do is to hold in your anger, stop thinking about it or think about something else, and focus on something positive. There is some danger in this approach if there is no action taken to resolve the issue.
   - If the need for outward expression is suppressed chronically, and there is no search for resolution, you are likely to turn your anger inward on yourself. Anger turned inward causes depression and the physiological effects of raising blood pressure, heart rate and the levels of your energy hormones – like cortisol, adrenaline, and noradrenaline, are not healthy.
   - The indiscriminate suppression of anger can lead to pathological expressions of anger, such as passive-aggressive behaviour (getting back at people indirectly, without telling them why, rather than confronting them head-on), or developing a seemingly perpetually cynical and hostile personality. People who are constantly putting others down, criticising everything, and making cynical comments haven't learned how to constructively express their anger.

3. ***Calming.*** Calming yourself down inside controls your behaviour as well as your physiological response. There are various ways to accomplish that.
   - <u>Relaxation</u>
     - Simple relaxation tools, such as deep breathing and relaxing imagery, can help calm down angry feelings. Practise them till you can call upon and use them automatically in any situation.
       - Breathe deeply, from your diaphragm; breathing from your chest won't relax you. Picture your breath coming up from your "gut".
       - Slowly repeat a calm word or phrase such as "relax," "take it easy". Repeat it to yourself while breathing deeply.
       - Use imagery; visualise a relaxing experience, from either your memory or your imagination.
       - Exercise tensing each group of muscles and relaxing them in succession; it can relax your muscles and make you feel much calmer.
   - <u>Cognitive restructuring</u>
     - Change the way you think. There is some truth in the suggestion that people who see the glass half full lead a fuller life than those who see it half empty.
     - Be careful of words like "never" or "always" when talking/thinking about yourself or someone else. They are inaccurate, generate automatic negative thoughts

that would either induce you to not exploring the possibilities of resolving the problem, or alienate and humiliate people who might otherwise be willing to work with you to find a solution.
- Remind yourself that getting angry does not fix anything, it only makes you feel worse.
- Use logic on yourself to beat the anger. Remind yourself that not everyone is against you, it is just some of the rough spots of daily life. Everyone wants things, and we all feel hurt and disappointed when we don't get them. These are normal reactions – frustration, disappointment, and hurt. Anger is not.

- Problem solving
  - Anger and frustration are caused by very real and inescapable problems in our lives. They are a healthy, natural response to these difficulties. Not every problem has a solution at that point in time. Focus on how you handle and face the problem, rather than persisting finding a solution. Remind yourself that the solution might only be found at a later time.
  - Make a plan, and check your progress along the way. Aim for the stars, but it is okay to land on the moon. Resolve to give it your best, but also not to punish yourself if the result is not ideal.

- Better communication
  - Listen, and not jump to and act on the wrong conclusions. Slow down and think through your responses. Don't say the first thing that comes to your head. At the same time, listen carefully to what the other person is saying and pause before answering.

- Using humour
  - "Ridiculous humour" can help defuse anger. Don't take yourself too seriously.

- Give yourself a break.
  - Avoid situations that make you angry by changing your environment or timing.
  - If you feel angry and "trapped", walk away and allow yourself to clear your mind.

Last but not least, ***try*** to find out what triggers your anger, and then develop strategies to manage those triggers.

If these approaches do NOT work, it's probably time to see someone.

Coping with failures

Everybody fails at some point.

The dos and don'ts in coping with failures are:

- ***Do***
  - Believe in yourself. Know that you can deal with failure.
  - Be persistent. Accept failure as a process. Quitters don't succeed.
  - Set your goals, anticipate failure and develop plans and alternatives.
  - Accept your responsibility for your failure and learn from each failure. You can't learn if you blame others or external causes.
  - Ask for help when you need to.

- ***Don't***
  - Procrastinate.
  - Assume the worse. Be aware of and don't delve in automatic negative thoughts.
  - Fear failure.
  - Fear success.
  - Be overcautious.
  - Be unable to make difficult decisions.

Confidence and self-esteem

People who have or pretend to have high self-esteem tend to behave confidently. Behaving confidently does not come naturally for the majority of us. It is a skill that we need to learn. What we want is a healthy self esteem so that we can develop healthy relationships at home and in school, learn life skills (e.g. assertiveness, decision making), expressing ourselves, being open to changes and take up challenges.

Confidence can come from within yourself, from others and from your achievements. There is nothing as addictive as the savouring of success!

If you feel you lack self esteem or self-confidence, ask yourself:

- Are you overly critical of yourself?
- Are you telling yourself negative things like "I'm forever failing" or "I'm never good enough"?
- Do you believe other peoples' comments about your inability to succeed or your faults?
- Do you have a poor opinion of yourself?

If you belittle yourself, why should others respect you?

Increasing your confidence and self-esteem

- Focus on what you have done and your achievements. Be proud of them. Being overly modest is not a virtue. It is as far a deviation from the truth as being boastful.
- Look for a model (someone who is confident) and learn from them.
- Act as if you were confident! With practice, you will be.
- Start with tasks that are small and achievable, and work your way up. Prepare thoroughly for the task so that you can be sure you are ready.
- Work on any skills you need to learn and feel that it is okay to experiment while you practise.
- Don't stop learning; you can never be over trained or over skilled for any challenge in life.
- Learn to relax and always smile.
- Reward yourself when you succeed.

LEARNING POINTS

- **Adolescent Mental Health is a part of the subspecialty of Adolescent Medicine as it is recognised that adolescents are a subgroup that warrant special attention.**
- **Disorders in adolescence can be divided into residual childhood problems, problems of/in adolescent transition, and early adult disorders/adult type disorders.**
- **Behavioural problems in adolescence may exhibit as disruptive behaviours, anxiety, mood disturbances, developmental deficits and social deficits.**
- **Adolescent depression can be missed as the symptoms can be atypical.**
- **At times, adolescent depression is the consequence resulting from the problems caused by the depressive symptoms that bring depression to attention.**
- **Anger management, coping with failures, building confidence and self-esteem are life skills that can help in averting psychological morbidities in adolescence.**
- **Most adolescent depressions can be managed successfully by the GP with the support of the family, in collaboration with a child & adolescent psychiatrist.**