# Clinical characteristics of adolescents referred for treatment of depressive disorders

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Low mood and depression often emerge during adolescence and are associated with long-term difficulties including increased risk of developing other mental health disorders, educational underachievement, low income/unemployment, and risk of suicidal behaviour. Major depressive disorder (MDD) is characterised by a number of possible symptoms including core symptoms of low mood or irritability, and anhedonia (loss of interest or pleasure). Additional symptoms could include suicidal thoughts, sleep disturbances, fatigue, changes in appetite, impaired concentration or ability to make decisions, psychomotor changes (observable restlessness or slowed behaviour) and negative self perceptions. Given the frequency and associated risks of having depression in adolescence, along with the wide variety of possible presentations of depression, it is important to understand the characteristics of depression in young people.

As part of the routine clinical assessment, demographic information including age, gender, ethnicity and socioeconomic status, was collected. Diagnoses were assigned on the basis of a DSM-IV semi-structured diagnostic interview with adolescents and their parents (Schedule for Affective Disorders and Schizophrenia in School Age Children; K-SADS), and symptoms of anxiety and depression were assessed using the Mood and Feelings Questionnaire (MFQ) and the Revised Child Anxiety and Depression Scale (RCADS), collecting both child and parent reports.

The mean age of the adolescents was 15.78 years (range 12-17), with the majority aged 15 or 16 years (60%). Most were female (85%) and white British (89%). Other ethnicities included white and black Caribbean, Asian, Indian and Pakistani. The social class of most families was classified as 'professional' (78%) according to Office for National Statistics Socio-economic classification. Forty-two of the 100 young people met criteria for a primary diagnosis of depressive disorder on the K-SADS (MDD n = 37; MDD with psychosis n = 3; schizoaffective depressive disorder n = 2). Of the remaining 59 participants, 23 met criteria for a primary anxiety disorder diagnosis, one participant met criteria for oppositional defiant disorder and 34 young people did not meet criteria for any diagnosis.

All participants with a depressive disorder met the core criterion of low mood or irritability, and half met the core criterion of anhedonia. Other very common symptoms were negative self-perceptions (86%), suicidal ideation (86%) and sleep disturbance (71%). Of the adolescents that met criteria for a primary depression diagnosis, 54% had comorbid disorders (most commonly social anxiety disorder, 32%; and generalized anxiety disorder, 14%). There was no difference in age or gender between those that did and did not meet depression criteria.

As expected, adolescent self-reported anxiety and depression were highly correlated. However, there was a significant difference between child and parent report of the young person's depression symptoms. The mean adolescent MFQ score was well above the suggested cut-off for clinically meaningful symptom scores (of 27.) In contrast the mean parent MFQ score was below the suggested clinical cut-off. Surprisingly there was also no association between child and parent reported symptoms of adolescent depression.

Treatment guidelines for depression focus on those with the disorder and services are typically commissioned and structured to provide treatment for young people with a diagnosis. Despite this, most CAMHs teams do not conduct structured diagnostic interviews and may therefore not distinguish between those with a diagnosis of depression and those who do not meet diagnostic criteria. This also raises questions about what treatment or intervention should be offered to young people who present with symptoms of depression but do not meet criteria for a diagnosis. Research indicates that adolescents who have sub-clinical depression are at increased risk of developing a depressive disorder and are likely to experience continued impairment if treatment is not provided. This could therefore present an opportunity to potentially prevent depression from developing for these young people, if input was provided at an earlier stage.

Rates of active suicidal ideation were very high in this study (86% of those diagnosed with depression, 35% of those with no diagnosis) and in excess of those reported in epidemiology and treatment studies. This is even more striking given that our sample excluded young people identified as at immediate risk. This level of risk may reflect a referral and selection process in UK CAMHs that prioritises young people who disclose thoughts of self-harm and suicide. This would be clinically understandable and may be the best way to prioritise scarce resources. However, the extremely high rate of suicidal ideation in the sample suggests that other adolescents with clinically significant symptoms of depression who do not disclose or declare suicidal thoughts, may not be referred for treatment and assessment. Such high levels of risk also present a significant emotional burden and workload for clinicians, which may not be acknowledged in commissioning, job planning or staff support services.

Finally, the lack of agreement on symptomatology between parents and their adolescent offspring is concerning. Initial contact with specialist CAMHs is typically made by parents rather than by young people themselves. This reliance on parents to identify depression in their children suggests that many young people with depression, may go unidentified and therefore untreated. One possible implication for service design and delivery, is that young people themselves should be encouraged and enabled, to recognise the symptoms of depression and have ready and direct access to services that offer assessment and treatment.

Key points:

Of 100 adolescents referred for depression to a routine public child and adolescent mental healthcare service in the United Kingdom, fewer than half met diagnostic criteria for a depressive disorder.
The most common symptoms of the depressed group were low mood or irritability, suicidal ideation, sleep disturbances and negative self - perceptions.
Parents and young people provided quite different reports of adolescent depression symptomatology.
There are currently no guidelines in place regarding (a) how to treat adolescents who do not meet diagnostic criteria for any disorder, but are experiencing distress, impairment and often risk, and (b) how to support and manage clinical staff who are dealing with high levels of risk.