Assessing Depression in Adolescents

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Question and Answer

TCPR:
Depression in teenagers can present quite differently from both adults and younger kids. Can you help us to understand how to go about diagnosing depression in teens?

Dr. Rappaport: I look for functional impairment when diagnosing depression in a teenager. So if I have a kid who has done relatively well in school and suddenly his or her grades are plummeting, that is a big red flag. Or if a teenager is showing up at the school nurse for vague somatic complaints, such as repetitive headaches that have already been evaluated by a pediatrician, I wonder if this teen is having trouble putting into words how bad he or she feels. Another clue is when a third party, like a guidance counselor or a school social worker, comes to me with a concern about some change in a teenager's behavior. Sometimes a teacher will become alarmed—for example, a teenager who is writing about Hamlet and interprets the line "to be or not to be" in a way that leads to a dissertation on his or her own existential questions.

TCPR:
In adult psychiatry, we are used to evaluating depression directly by asking the patient questions like, "Do you feel depressed? Have you been sleeping? Have you been able to enjoy anything?" How should we approach teenagers differently?

Dr. Rappaport: I find that if you ask kids if they are depressed, they may be insulted. I often tell my child psychiatry residents: "Don't ask kids if they are 'depressed'—use any other word." I tend to have more success when I ask if they feel "irritable." They can admit to being irritable and being angry, but they are less likely to admit to feeling down and depressed. And in fact, that is a common way that depressed kids will present—they might be fighting with their parents; or they might be getting suspensions and detentions at school. In terms of assessing for anhedonia, I try to find something that gets that particular teen a little bit animated. Does he have a favorite music group? Does he have an extracurricular activity that he loves to do? A completely flat and restricted response is often his way of telling you he doesn't have any interests.

TCPR:
But how do you know whether a teen's flat responses don't just reflect discomfort or resentment with having to see a psychiatrist?

Dr. Rappaport: To avoid that problem, I always tell teenagers at the outset that they are in charge. I'll say something like, "If after talking to me for a while you think I am a complete dud, fire me." They always seem a little bit surprised that I have put them in the driver's seat. I will also make a joke about

how seeing a psychiatrist is about as much fun as going to the orthodontist, and maybe even *more* painful. I tell them, “I will be asking you a lot of difficult questions, but I am doing this to figure things out, to make things easier for you.”

TCPR:
How do you assess sleep in teenagers?

Dr. Rappaport: Sleep is a really hard one, because kids normally sleep an enormous amount—up to 14 hours. So I don’t focus on how much someone is sleeping, rather I look at how sleep habits affect his or her functioning. A key question is whether a teenager is sleeping so much that he or she is not able to get to school. One modern complication is the computer; these kids might be on Facebook until three in the morning, so you have to tease these kinds of issues out during the interview.

TCPR:
What about assessing suicidality in teens?

Dr. Rappaport: I find it crucial to ask if any of the teen’s peers have committed suicide or have felt suicidal. Also, I ask if friends are worried about him or her being suicidal. And of course a key question is whether there is access to guns. We know from the literature that teens are two times more likely to kill themselves if there is a gun in the house (Brent DA et al., *N Engl J Med* 2002;347(9):667–671).

TCPR:
Are there any other clues to suicidality that you have found useful over your years of practicing?

Dr. Rappaport: I have learned through hard experience that you need to trust your own gut-level response. For example, a patient was telling me about wanting to hang herself, and said that the reason she wasn’t going to do it is that she didn’t think the knot would hold. I had this enormously ominous feeling when she said that. And yet I didn’t end up hospitalizing her at that point because she assured me that she wasn’t suicidal. But the day before her next scheduled appointment, she took a significant aspirin overdose. This is not the kind of thing you can study empirically, but if you have a sense of dread when a kid is talking about suicide, you need to act on that.

TCPR:
How do you evaluate teenagers who say they are “moody”?

Dr. Rappaport: This is certainly a situation where clinicians can get tripped up. Teenagers are moody by nature, so it is important to talk to the parents and ask them to describe concretely when their child is moody, how long it lasts, and if their last moody episode was similar to the current one. Some degree of moodiness can be a normal part of development, but if a teenager is having two-hour stints of crying and shutting himself in the room, that is different. Sometimes the parents just see this behavior as their child having a grumpy personality, but as clinicians, we have to be very astute in order to draw out behaviors that may in fact reflect a biological depression.

TCPR:
What about substance abuse?

Dr. Rappaport: There is an ongoing debate about whether substance abuse causes depression in teenagers or whether teens use substances to treat an undiagnosed depression. Regardless, it is important information, and getting it is tough, because teenagers do not want to tell you that they drink massive amounts of alcohol during the weekend or smoke a lot of marijuana. But there is a clear correlation: 23 percent of teens with depression use alcohol weekly (Goldstein BI et al., *JAACPA* 2009;48(12):1182–1192).

TCPR:
How are learning disorders related to depression?

Dr. Rappaport: I wrote about this issue in a letter to the editor in the *New England Journal of Medicine* (Rappaport N, *N Eng J Med* 2003;348(5):473–474). The typical situation is a kid who has a reading disorder that wasn't diagnosed because he is bright and was very determined to succeed in elementary school. But then he gets to high school and the academic challenges increase, and this can lead to depression. I often screen for learning issues by asking things like, "What is it like for you to read a book? How long does it take for you to do assignments?"

TCPR:
Child psychiatrists are in short supply, and in many cases, they handle the medications and refer to colleagues for therapy. Do you have any suggestions for how to work effectively in the split treatment model?

Dr. Rappaport: In order to successfully split treatment, you have to trust the judgment of the therapist; especially that he or she knows when to contact you. The worst case scenario is when a patient shares suicidal thoughts with a therapist, who determines that the kid is not currently suicidal and does not inform the psychiatrist. That puts the psychiatrist in an incredibly vulnerable situation, because he or she may make inappropriate decisions because of a lack of crucial information.

TCPR:
Are there any more common problems that arise?

Dr. Rappaport: Noncompliance with medication is a huge issue with teenagers, and you can easily be duped. You see a child or a teenager who is not responding to a medication and make all these fancy changes, then come to find out, he or she was not taking the medication at all. A savvy therapist might have heard about the patient's ambivalence about medication. To try to prevent this problem, I often say to the teenager, "I am not getting a kickback from the drug company. I don't have any financial investment in you taking the medication, but it's a waste of our time if you don't take your meds and you don't tell me. If you don't want to take it, just let me know."

TCPR:
What other information do therapists often learn that is important for the psychiatrist to know?

Dr. Rappaport: They may know more about the family dynamics and changes in family situations that could impact treatment. They hear more about boyfriend/girlfriend issues, dating violence, pregnancy, birth control, and so on. You may eventually find out about it, but they may know it first. When I am at a school-based health center, we have a structured arrangement where once a month we sit down as a

team and get information, which is a luxury of being in a clinic and being able to do coordinated care.

TCPR:
What do you tell parents about the possible side effects of worsening suicidality on antidepressants?

Dr. Rappaport: I try to share the responsibility with parents and talk through the numbers. I tell them that one in 140 kids can have a suicidal response to an antidepressant, and I describe the studies. I refer them to two articles that I have written about the black box warning and how to interpret it. **[Ed note: See the sidebar for information on these articles.]**

TCPR:
Thank you, Dr. Rappaport.

What To Ask?

Some key questions to help you ascertain depression in your adolescent patients

- Have you been feeling irritable or angry?
- Have you been getting in more fights than usual with your parents or siblings?
- Do you have such a hard time waking up in the morning that you're often late for school?
- How are you doing with you schoolwork? How long does it take you to get through an assignment?
- Do you have any friends who have thought about suicide?
- Have your friends been worried that you might be suicidal?

Resources for Understanding the FDA's Black Box Warning

Rappaport N et al., *J Pediatr* 2006;148:567–568. View it online at http://bit.ly/9wq19s

Rappaport N et al., *J Pediatr* 2005; 147(6):719–720 View it online at http://bit.ly/a5av4w

Visit www.nancyrappaport.com/publications for more information on treating depression in adolescents

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