Adolescent Mental Health: depression, suicidality and cyber-bullying

Collaboration across disciplines

Tim is a 17 year old student in year 11 at high school.

He is the eldest of 3 children. His parents are separated and he lives with his mother and two sisters. He has regular contact with his father.

He presents on the insistence of his mother, who is concerned about his irritability, argumentativeness, unhelpfulness around the house, disinterest in his homework, falling grades, and the amount of time he spends going out with his friends.

You have not seen Tim for several years, as he has been generally healthy apart from the usual childhood infections, injuries and skin complaints, although he is also somewhat overweight. As far as you know there is no PH of psychological problems. However, you recall he is a bit of a sensitive kid.

You know his parents who see you as their doctor. Tim's father has a drinking problem. He is an 'unhappy' man, but not clinically depressed. He constantly blames others for his misfortune and his underachievement in life. Tim's mother is a tense individual but again, she does not have any diagnosable mental illness. Tim's parents have a poor relationship with each, and there were frequent arguments between the two in the years leading up to a fairly acrimonious separation 4 years ago. You know that a paternal uncle apparently has bipolar disorder.

You are already running 20 minutes behind. Tim's mother has booked a standard 15 minutes consult. Your heart sinks.

Facilitator: As Tim's GP, how do you intend to proceed?

What are the essential tasks of this particular consultation?

You decide to talk with Tim on his own. Your plan is to try to make him feel comfortable, and to find out a bit more about the story, without necessarily going into every last detail. After explaining issues of confidentiality, you start by asking him if there is something you can help him with today. Tim is clearly unhappy about being brought to see you and is not particularly forthcoming. However, with some gentle prodding he eventually starts to give his side of the story.

Tim believes that his mother is making a mountain out of a molehill and there really is no issue, other than that he is sick of her constant nagging. He believes that her nagging caused his father to leave, and he is angry with her about this. By the same token, he also gets frustrated with his father and states that he is unreliable and more interested in talking about himself and his problems. Tim argues with his mother practically every day. He does not see it as a problem, since every teenager argues with their parents.

You decide to pursue the rest of the information by starting with an overview of this general health. Tim tells you he generally feels well in his health, although he is often tired. He stays up late most

nights, spending time on the internet, playing games or communicating with friends. He often goes to bed at around 2am and has to wake up around 7.30am to get to school. He has missed school on several days in recent weeks. On weekends he sleeps in until midday or later. His appetite is variable, but he has not lost any weight. He eats a lot of convenience food.

He admits that he does not do much homework and that he has fallen behind on a few assignments. There is one particular teacher at school who gets on this back all the time about this and his poor performance in his subject. He does not really enjoy school and has been thinking about dropping out at the end of the year. He is not sure what he would do instead. Apparently, there have been some comments from the year coordinator that unless he lifts his game he made be asked to leave. Tim says they don't like students who are going to drag the year 12 average down because it would look bad for the school. Tim is not involved in any sporting or other extra-curricular activities, but works part time at a fast food outlet. He agrees that he spends a lot of time with his friends, although recently he has had a falling out with one of his peers, and this has somewhat 'split' his friendship group. He used to visit friends at least 3 times a week and go to a party practically every weekend but he is now spending less time with them. He says he does not want to talk about it.

Sensing he has talked about as much as he is going to, you decide to ask some specific questions about his mood. He denies feeling anxious or depressed, but admits to feeling stressed by the fall out with his friend, the problems at school and his mum's constant nagging. He can't be bothered with his school work and thinks there is no point trying at this late stage (term 4) as he is going to fail anyway. He is pessimistic about his future. He admits to occasionally thinking about what it would be like to be dead, but he denies any suicidal intent or plan. Throughout the interview he appears quite tense and irritable when talking about his parents, the school and his friends. Otherwise his affect is lowered and not very reactive.

What other information would be required at this point?

What should happen next?

You decide to finish off the consult by briefly summarising what he has told you, to make sure you have got the gist of his concerns. You avoid taking sides, and making a diagnosis, and suggest to Tim, that it is not uncommon for young people to feels stressed when things at home and at school are not going well, but that it is important not to let these sorts of things get too out of control. You also tell him you are a bit curious about his tiredness and whether there may be something you could do to help this. You ask him how he would feel about having a few blood tests to check for anaemia, or whatever, and for him to come back next week to see you so you can give him the results and do a bit of a check-up. Tim appears agreeable to this.

You also ask if you can bring his mother back in for a very quick chat, together with Tim, so that you can explain to her what your plan is. Though reluctant he agrees. You ask his mother to come back into the room, and once again, you state the same thing about stress, how common it is, but at the same time how it is important to try to resolve these things. You mention that you have decided to ask Tim to get some blood tests done and that would like to see him on his own next week. While she appears a bit miffed about not having had more time with you today, or next week, she agrees with the plan as she is happy that something is being done.

You give Tim the pathology request slip and ask him to make a half hour appointment for sometime next week.

What comment would you make about the GP's handling of this consult?

The following week Tim comes to see you. He has not done his blood tests and he says he is only here because his mother 'forced him to come'.

You thank him for coming, and try to reflect back to him your understanding of the frustration he is feeling, and your role as his GP and not just his parents GP. You emphasise you are not here to judge or take sides, but to try to help him in a way that is useful to him.

Once again, it takes a while for Tim to 'warm up' but he eventually starts talking. He mentions how angry he is with one of his friends, who he had a fight with about a month ago. His friend, Max, just for a joke, spread a rumour about Tim having had sex with an unpopular girl at school. The rumour circulated quickly, and Tim started being the butt of peoples' jokes. As a result, he got into a fight with his 'friend', but this then led to a falling out with most of his friendship group, who supported Max. Only a few of the group took Tim's side.

Tim states that he has since been subject to a barrage of emails and SMSs teasing him. He recently received a 'doctored image' of his face and the girl's face superimposed onto two Sumo wrestlers with an accompanying lewd caption.

At this stage, Tim starts crying briefly, but quickly tries to stop himself. He clams up again, but again, with some gentle encouragement he starts to tell you how hurt he feels by his friends. You ask him is he has told his mother, and he starts to get angry and say, she wouldn't understand and she wouldn't help. 'All she is worried about are my grades and so I don't wind up a useless loser like my father."

He tells you more about his relationship with his mother and father, which is clearly tense at present. However, he is prepared to acknowledge that his mother is concerned about him and that she is the one who brought him here in the first place.

You decide to complete your assessment, but finding out about his drug and alcohol use, his sexuality, and to recheck his mental state.

Tim states that when he is with friends, particularly at a party, he will drink alcohol, sometimes to excess. He says that he would get really drunk about once a month. However, he has had less contact with them of late, and so he has been drinking less. He has occasionally smoked cannabis, but has never used other illicit drugs.

When asked about his sexual interests, Tim states that he regards himself as heterosexual but has never had a girlfriend. He admits that he did have an interest in the girl that he is alleged to have had sex with, but says he does not want to have anything to do with her now.

On mental state examination this time, he admits to being sad most of the time since the fall out with his friends began. He also admits to being much angrier with his mother, but he says it's because she is always on his back. Since the last consult, he has started to think a bit more about death, and the thought of maybe being better off dead, has crossed his mind a few times. However,

he claims that he does not want to give ‘them’ the satisfaction of getting rid of him, and he denies any intent, or actual plan.

What should the GP do next?

The GP decides that Tim is possibly suffering from depression, in the context of bullying at school, pressure from his teachers and mother to perform well at school, and his perceived difficult and unsupportive relationship with his parents. The GP notes that Tim’s sensitive personality may also be playing a role in his condition.

The GP assesses Tim’s risk as low-moderate, but feels that he needs some fairly urgent attention; otherwise things will continue to escalate. The GP thinks that it would be best to refer Tim to a psychologist.

What should the GP tell Tim?

What are the GP’s referral options?

Case of Tim: psychologist point of view

Having read the GP's letter, I would use the HEADSS assessment tool, to take a comprehensive psychosocial history and psychological risk assessment of Tim, ostensibly to confirm the GPs conclusions.

Such an assessment should provide me with information about Tim’s functioning in key areas of his life, including his home life, what's happening at school, when his part-time employment, eating and exercise. It would also cover his activities when not at school, the nature and extent of his peer relationships, any alcohol or drug use, issues around sexuality and a standard screening for suicide, depression or low mood.

Such an assessment provides a systematic framework for developing a good rapport with the young person, it enables a risk assessment and screening for specific risk behaviours, identifies a young person's risk and protective factors, using a five world model and identifies areas for Intervention and prevention.

After introducing myself and explaining confidentiality, I would typically begin with a statement such as “…in order for me to get a good understanding of each of my clients, I like to ask them about different areas of their life and how these might be affecting their health and well-being. If it's okay with you, I would like to start by asking you a few questions about how things have been going in different areas of your life, is that okay?”

At the conclusion of such an assessment, I should have a profile of Tim’s psychosocial well-being, the overall level of risk he might face, a list of specific risk factors in his life, as well as any protective factors along with a management plan for further intervention, which I'll discuss with him and his mother. I would conclude by complementing him on his strengths, in the areas of his life in which he's doing well. I would identify and discuss any issues of concern or help him to identify the risks associated with his behaviour and to identify strategies for making better choices.

At the second session, I would probably administer some standard psychological tests (BDI, CBCL) to evaluate the presence and depth of any depressive illness, giving feedback to Tim and (with his permission) to his family. I'd be keen to assess Tim's level of understanding about his self-defeating behaviours that might be linked to his depression, if present and interpret his acting out behaviours as a reflection of the depression. My aim would be to teach Tim the connection between angry, irritable behaviours and feelings of hurt and sadness.

During the second session, I would seek to reinforce Tim's open expression of underlying feelings of anger, hurt and disappointment. I would also explore any fears regarding abandonment or the loss of love from others and help him to specify what is missing in his life, that might be contributing to his unhappiness and encourage him to express his emotional needs to significant others.

During the third session I will introduce the concept of cognitive behavioural therapy in order to help Tim identify any internal cognitive monologue that reinforces his feelings of helplessness and hopelessness. The aim would be to teach Tim to recognise any unhelpful, self-defeating self-talk and to learn to dispute such cognitions and replace them with positive self talk that strengthen feelings of self acceptance, self-confidence and hope. I would introduce him to do some online CBT programs strategies such as www.moodgym.edu.au , programs that build social and emotional competencies such as www.reachoutcentral.com.au and assuming he is a reader recommend that you buy the CBT manual for teenagers written by Sarah Edelman entitled 'Taking charge! : a guide for teenagers : practical ways to overcome stress, hassles and upsetting emotions (http://www.fls.org.au/takingcharge.asp)

During subsequent sessions, we would complete homework assignments and I would use the K10 to monitor his progress, and encourage him to engage in school extracurricular activities and monitor his diet, his sleep and any alcohol and other drug use. I would send the GP a letter outlining our progress after each session.

GP Mental Health Treatment Review

As agreed, Tim came back to see his GP after the 6th session with the psychologist.

The psychologist's letter was comprehensive, although you mainly read the formulation, treatment provided to date and suggestions about further management, including further counselling sessions.

When asked how things were going, Tim responded that things were a bit better, but not great. While he was feeling a little less annoyed by his mum, and a little less stressed about his school work he still felt angry and unhappy with Max and still felt on the outer with some of his mates.

You talk some more about his home, school, work life and general well being, and you are left with the impression that Tim is heading in the right direction, but could probably benefit from more therapy. He seems fairly agreeable to this.

During the conversation about continuing on with the psychologist, Tim mentions something else that he has not told you, or the psychologist before. For a few weeks now, he says he has been hearing a voice in his head that he is a bit scared and worried about. You ask him to describe it in a bit more detailed. Tim is pretty vague about it. It appears that it is a male voice, not his own, that says critical things. You ask about other perceptual disturbances, and Tim mentions he once thought

he saw his deceased grandfather walk into his room, but that was when he was stoned. He also mentions feeling a ‘bit paranoid’ at times when he used cannabis and thinking that everyone was talking negatively about him. While self conscious he does not appear to have true paranoid or other delusions.

Given his relatively slow progress, the issue of the ‘voices’, and the FH of bipolar disorder, you decide to encourage Tim to continue to see the psychologist, but also ask him how he feels about seeing a psychiatrist for an opinion about whether other treatment, like medication, may be of benefit to him. You tell him there is a new psychiatrist who is really experienced in working with young people who has just moved into the area, and you reckon you could get him to see Tim pretty quickly, maybe just as a once off. Surprisingly, Tim agrees.

Case of Tim – psychiatrist review

Tim has mild depressive symptoms that are worsening. His presentation is quite typical of adolescent depression in child & adolescent psychiatry. However a diagnosis like “depression”, whilst important in highlighting Tim needs assistance, risks narrowing and oversimplifying the reality of Tim’s experience.

A biopsychosocial formulation that includes a fullish understanding of his developmental history and more recent life context is necessary to address all or at least the most relevant contributing factors.

Over 3 sessions with Tim, I – like his GP – focussed on developing a therapeutic rapport that led to an alliance in dealing with his problems. Like his GP, I checked his suicidality and Tim reiterated his increasing suicidal ideation but still, thus far, lack of plans or intent. I weaved into conversation with Tim how I had seen many suicidal people and for virtually all there came a time when they were again feeling normal and happy and so glad they had not acted on or succeeded in suicidal behaviour. How suicidal thinking seems to reflect the human brain's problem-solving instinct in looking for an escape when feeling stuck, but in reality nearly everyone who gets stuck and depressed later gets better. Thus having a safety plan is like respecting your future recovered self. Tim found our discussion, talking in generalist terms, helped him externalise the suicidal thoughts and discuss them in a rational context. We identified his maternal uncle and aunt and a male teacher as support people in addition to his GP and private psychologist, plus he also was given emergency after hours numbers.

I enquired about progress of his depressive symptoms and lifestyle. Despite advice from his GP and psychologist Tim was still sleep deprived and up late on the Internet, eating a high carb junk food diet and was going to start exercise but always "next week". He still felt humiliated and alienated from this stuff his peers since the cyber-bullying.

I enquired about other symptoms. He'd always been a "worrier" and unsure in social situations but never had any panic attacks. Recently he had heard a male voice telling him he was "nothing" and "you're to blame for it", mainly whilst going off to sleep. He denied any other psychotic symptoms, and had no OCD or eating disorder symptoms. He had had episodes at parties where he felt "high" and much more talkative than usual, usually under the influence of alcohol, but these were not sustained and his mother later confirmed he'd never had any rapid tangential speech, grandiose ideas or other manic/hypomanic symptoms. Tim denied nightmares or flashbacks and said he did

have unhappy memories of a young age in witnessing his father verbally and physically abusing his mother, also of being "yelled at" a lot by his father when little.

Tim allowed me to interview his mother in his presence about his early life. She reported a normal full-term pregnancy and birth, Tim being a wanted child whose arrival papered over cracks in the parental marriage for a time. Nonetheless she described his father as "useless" when it came to helping and she felt isolated in the city they'd moved to find work. Her own and her husband's childhoods' had both been characterised by alcoholic abusive violent fathers, she had been determined to give a different life to her children. She denied postnatal depression but said she had been over protective and anxious of Tim and her husband had become jealous. This worsened after the birth of Tim's younger sisters and led to eventual domestic violence and an unhappy marriage that eventually ended when Tim was aged 13.

Meanwhile Tim was a clingy child with separation anxiety as a preschooler and often missing school over the years with psychosomatic complaints. Around the age of 10, Tim's father had taken more interest in Tim, taking him to see sporting matches, kicking the footy with him and watching action movies late at night with Tim despite protestations from his wife. Tim was very upset at his parents' separation, initially siding with his father but then later feeling let down as his father's drinking and self absorption worsened.

Speaking alone in the third session Tim confided he had really like the girl who was the subject of his being bullied. He had often been bullied over the years at school and saw himself as less worth than "cool" classmates – a "nothing" like the voice said. I discussed with Tim how voices like this are actually quite common for adolescents who get depressed and who have been yelled at when little and bullied at school. They are like "echoes of verbal abuse from the past" and often occur when sleep deprived, particularly near bedtime, and can be seen as "a bit of a bad dream starting whilst still awake." Given his otherwise rational mental state, they were not a sign that he was going "mad."

I discussed with Tim (and later with he and his mother) how his predicament of feeling depressed had several causes – and addressing each of them should in time see him recover and maybe come out a stronger person than before.

I paraphrased attachment theory and rank theory – how humans are tribal social species and evolution requires socialising, approval by the group and team participation to add survival value for the tribe. Thus socialising is rewarded by the experience of fun, happiness and belonging and participation by positive feeling from praise and approval of others, but conversely painful feelings result from loss of relationships and disapproval by others.

Tim had had a succession of losses – his father, his parents' separation, the ambivalent feelings towards the girl, no longer socialising with his mates and the falling out with "Max". He was suffering from disapproval by his peer group and a particular teacher. No wonder it was depressing him.

Also, using the whiteboard and drawings of the brain, nervous system and body – I described how physiologically evolution has designed us to cope with acute stress but that chronic stress upsets our metabolism (HPA-cortisol axis, sympathetic nervous system, amygdala hyperreactivity, less frontal

lobe clear thinking). Chronic inflammation results and this is the latest theory behind depression i.e. a chronic overuse state – thus the need for relaxation and turning on the brain's natural parasympathetic nervous system relaxation. This can happen naturally with yawning, sighing and laughing that stimulate the vagus nerve and induce autonomic equilibrium. Similar to these natural embedded relaxation networks in the nervous system is slow diaphragmatic (yoga like) breathing used in meditation and "mindfulness" practices. In fact elite sports stars, politicians, actors, singers and myself (e.g. in psychiatry exams, daily work) use this technique. Tim was highly sceptical but finally won over by scientific explanation. He watched me "make a fool of myself but a relaxed fool" and copied the technique noting he did "actually feel more relaxed". He agreed to practice it, especially in bed at night.

Similarly, a humorous psychoeducational description of how a regular circadian rhythm, exposure to adequate sunlight (melatonin production to aid sleep, vitamin D which is believed to ward off this depression), exercise, nutritious food and avoiding high calorie low nutrient inflammation inducing junk food that can worsen mood (Tim was familiar with the documentary "Super Size Me"), how Omega3 fish oil supplements can be anti-inflammatory and there is evidence for antidepressants effect – are all important in sustaining normal body and mind functioning and consistent from an evolutionary point of view with how 17-year-old Stone Age lads would have lived.

Tim actually did start watching the Internet/TV with red tinged sunglasses late at night to reduce blue light that was interfering with his circadian rhythm, he would turn the screens off by 11:30 PM, and actually take a book to bed. He found that slow diaphragmatic breathing helped him relax in bed and get to sleep earlier. He agreed to set his alarm to wake by 10 AM at the latest on weekends. He started walking the dog and riding his bike to a friend’s house. He spent a little more time outside and took vitamin D supplements after his serum level came back showing severe depletion. He took omega-3 fish oil supplements and ate more fruit and veg and a bit less junk food. Tim's cooperation came fairly easily because therapeutic rapport had been gradually and tactfully established by sensitive engagement with him by his GP and psychologist and I took three sessions, rather than rushing the psychiatric assessment.

The year coordinator, having received a letter of explanation about Tim's depression from myself, arranged to lighten Tim's workload and it was agreed he would pass year 11 based on course work from earlier in the year. Though Tim knew he would need to do some revision in the holidays in preparation for year 12. This relieved his fear of having to repeat a year, something he felt would be humiliating.

From a psychodynamic perspective Tim had won the "Oedipal conflict" with his father. This is not a healthy state for an adolescent lad. Tim had become overly dependent on his mother through his childhood and to a great extent she had become overly dependent on him. Between age 10 and 13, whilst his father was functioning better, Tim was starting to identify with his father and individuate from his mother. However all this dissipated after his parents’ divorce. He regressed into an ambivalent hostile dependent relationship with his mother. He felt rejected by his father, whose deterioration in drinking and personality robbed him of a positive role model, led to feelings of shame and a lack of confidence in his own future. His ambivalence towards his mother was perhaps replicated in his ambivalent feelings towards the girl he was attracted to, but who he felt ashamed

of due to the bullying. His feelings of rejection by his father were perhaps replicated in the rejection by his best friend Max.

Family therapy would certainly have helped him in this situation, but given the level of acrimony between the parents was not possible at this time. However dyadic work with Tim and his father by his psychologist led to significant repair in his relationship with his dad who reduced his drinking and reengaged in some positive activities such as taking Tim to see the Ashes cricket. Later on dyadic work could be done between Tim and his mother. Tim wasn't sure why, but somehow his mother had seemed less annoying once he had reconciled to some degree with his father.

A male teacher who Tim trusted (Tim didn't like the school counsellor who early on had, he felt, breached confidentiality by telling Tim's mum of her concerns) agreed to have a session at school with Tim and Max to sort out their differences. Max was a powerful player in cliques at school and high on the pecking order. Tim felt more comfortable once again being part of the group with a rise in status and respect amongst his peers restored. However he also felt strengthened to counsel Max to tone down his teasing and sarcasm towards some of the other students, for whom Tim had empathy.

Tim's GP had asked whether he should be started on fluoxetine. I informed his GP and also discussed with Tim and his mother how the academic literature, when results previously hidden by drug companies had come to light, showed that SSRIs tended to probably only work in adults and some older adolescents with more severe forms of depression, although many people had a beneficial placebo effect. However SSRIs sometimes help people with severe anxiety, and if his problems persist may eventually be worth a try given his anxiety symptoms. On the other hand, there was a family history of lithium responsive bipolar disorder in his paternal uncle and although contentious there is a possibility of SSRIs inducing mania in predisposed individuals so that was another risk worth avoiding. Also some people seem to have withdrawal reactions and difficulty getting off SSRIs and perhaps about 1 in 50 can get a serious suicidal/agitation/aggression reaction - so leaving fluoxetine as a last resort made sense. This discussion became part of the general discussion about "natural antidepressants" of lifestyle factors, relaxation, behavioural activation, socialisation, reconciliation and talking about his stress.

I did however discuss Temazepam, and ask his GP to prescribe it for PRN usage up to 3 nights per week, with most of the pills held by his mother. Tim found this a helpful adjunct some nights to relaxation, just knowing he could get a drug induced sleep roughly every second night was a bit of a relief.

I was happy to refer to him back to his psychologist, GP and the helpful male teacher at his school, noting that I would be happy to review him should his progress falter.