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Who gets depressive illness?

Anyone can get this illness: we are all potentially at risk. People of all ages, from every culture and every socioeconomic group can become ill with depression. What differs in different ages and cultures may be the way that the illness shows itself.

Depressive illness in a teenager may look very different from depressive illness in an old person. The depressed teenager may be very tired, lacking in energy and irritable. The depressed older person may be restless, tense and sleepless. Depressive illness in, for example, rural India may show itself with extreme concern and distress about physical complaints rather than tearfulness and low mood, which may be the dominant features seen in a depressed European. The illness, whoever it affects and whenever it strikes, is equally disabling but differently expressed.

In this chapter we discuss some specific groups of people who may become depressed, and the different ways in which they may be affected, including children, adolescents, women who have recently had babies or have reached the menopause (and discuss whether men may experience anything similar), older people, people addicted to alcohol and drugs, people with seasonal affective disorder (SAD) or chronic fatigue syndrome. We also talk about how bereavement, shock and injury or violence can trigger off a depressive illness.

Depression in children

Depressive symptoms or features (as opposed to depressive illness) are common in emotionally disturbed children. Serious depressive illness in children is very uncommon and may occur in about 1 in 1000 children aged 10–11. Less severe depression occurs in about 2 children in 100. Much more commonly in children, depression is expressed as a behavioural disorder, or shows itself with bodily complaints, e.g. worry about health, abdominal pain, headache and

fatigue. Deliberate self-harm and suicide are exceedingly rare before adolescence. Teenagers' worries about growing up often include weight, appearance, relationships, sexual orientation, and what other people will think about them. All of these difficulties are helped by talking, although some – such as being uncertain about one's sexual orientation – may still not be easy to discuss nowadays.

Children and adolescents can be treated with antidepressants. Usually the newer antidepressant drugs (SSRIs) seem to be more effective than the old-fashioned drugs. A central and key part of treating a child or adolescent who is depressed is working with the family to help them make necessary changes. Involving school or college is not only advisable but is likely to be extremely helpful in the treatment of a depressed young person. Depression in a child or adolescent may be a sign that something very serious is wrong in the family, the environment or at school. Looking at, and trying to deal, with difficult social, family or school situations may do as much as, if not more than, medication can usually achieve.

Adolescence and depression

Before puberty the rates of depression in boys and girls are equal. After puberty twice as many girls as boys become depressed.

About 5 adolescents in 100 become depressed. Depressive illness in adolescents can be difficult to spot. Anger, irritability, withdrawing from friends and alienation from parents, academic underachieving, low self-esteem and sadness may all indicate depression – or be a reflection of the challenges and turmoil of normal adolescence. The changes brought about by depressive illness in adults are also seen in adolescents, but sleep disturbance is less common (adolescents are famously good at sleeping!). Delusions (abnormal beliefs) and hallucinations (abnormal perceptions) are less common than in adults.

Depression in adolescents, as in adults, may be linked to excess alcohol. Parents are often unaware of how much their child drinks – the average alcohol intake in a 15-year-old is 7 units a week. Some will drink nothing, others the average amount, and others far more. Adolescents may start drinking to try to make themselves feel better. The same is true of street drugs. Once alcohol or substances are used regularly, secondary problems occur. Finding the money to fund the habit becomes very difficult, and the problems rapidly compound.

There is more information about alcohol and substance abuse later in this chapter.

The disturbing rise in suicide rates in 15 to 19-year-olds may well be linked to the increase in alcohol consumption and the use of street drugs in this age group. It is never helpful to think that your child would 'never do such a thing'. There is huge peer pressure on adolescents to drink or take street drugs – they are all very vulnerable.

My son says he is depressed but I don't want him to go on antidepressants! Is there anything else I could do to help him?

NICE have now issued a helpful guideline on the treatment and management of depression in children and young people. Briefly, the guideline (see ***Appendix 3***) recommends that:

> . . . children and young people with moderate to severe depression should be offered psychological therapy (such as cognitive behavioural therapy (CBT), interpersonal therapy or family therapy) as a first choice.
>
> Antidepressant medication should only be used with children or young people with moderate to severe depression together with psychological therapy and should not be offered at all to children with mild depression.
>
> Sometimes the parents of the depressed young person may have psychiatric problems too (particularly depressive illness). Their needs will also need to be addressed.

Specialist advice is almost always sought before considering treating a child or adolescent who seems to be significantly depressed, as so many issues may be involved, e.g. education, family relationships, and the health of other family members. The Child and Adolescent Mental Health Services (CAMHS) are very hard pressed in many parts of the country and it is not easy to get quick access to their care. We say elsewhere that the supply of the psychological therapies mentioned above is also quite limited.

However, it is essential to give the greatest priority to children with mental illness as not only can their whole education and personal development be severely hindered by these illnesses, but they do tend to respond to treatment well, changing and recovering as they grow older.

My daughter is 14 and I think she's really depressed. I know how she feels because I went through the same thing in my late teens. I've asked my GP about putting her on Prozac or something similar, but she seems reluctant. Shouldn't she prescribe it for her?

Teenagers and younger children can certainly become seriously depressed. Adolescents need careful treatment because they are going through all the stresses of adolescence, growing rapidly and facing all sorts of new challenges in their lives, and not least because it's not easy to know what they're thinking. Also, children might go to the doctor with physical symptoms, so that depression is visually very hard to recognise. Antidepressants of some sort may well be very helpful for your daughter.

However, many GPs would wish to ask the advice of a psychiatrist with special skills in this situation rather than engage in treatment of someone so young themselves. There are specialised counselling services for teenagers such as Off the Record (see ***Appendix 1***) but, if she seems seriously depressed at her age, she definitely needs medical attention too. Ask the doctor to refer her to a child psychiatrist.

Young Minds is a national charity committed to improving the mental health of all children. Services include the Parents' Information Service, a free, confidential telephone helpline offering information and advice to any adult with concerns about the mental health of a child or young person. The free telephone number is 0800 018 2138. See ***Appendix 1*** for more information.

My nephew was treated for depression aged 18. He's OK now, and at University, but takes his final exams next year. We're worried how he'll cope with the stress.

First of all, make sure he knows that you are helpfully concerned, that he can talk to you if he runs into a problem, and that you will keep in touch with him yourselves just as general friendly support. Looking after himself generally is important, and we have suggested a number of self-help tactics in Chapter 4.

Secondly, be sure that he is aware of the sources of help if he does start to feel under stress or overwhelmed. These start with his tutors, and would include the University Health Service, local counselling services (most universities have their own counsellors) and phone

help lines such as the Samaritans or a local Night Line service (see ***Appendix 1***).

My teenage nephew used to be quiet and generally kept a low profile. Over the past few months he has taken to riding his motorbike very fast and has had a whole string of girlfriends.

The distinction between reckless behaviour and what normal young men do for fun may be a very fine line. There may be nothing wrong. Recklessness, however, can be part of a breakdown of normal behaviour in the setting of drinking too much, or taking street drugs – both of which numb judgement. The risk-taking behaviour can also include unprotected sexual activity or having sex with multiple partners. Any marked change in behaviour in a young man should alert those around him to the possibility of substance misuse. Occasionally some more risky behaviour emerges from self-destructive thoughts arising in a depressive illness.

I am a teenager and I have had to spend some time in an adolescent hospital unit as a result of my depression. I'd like to know what decisions I can make about my own treatment.

The Headspace Toolkit (see ***Appendix 1***) is designed for young people who may be in an adolescent psychiatric unit, or who are not in hospital but are in contact with the psychiatric services.

It takes a self-advocacy and rights-based approach for this group. Designed with the assistance of young people with experience of adolescent units, the toolkit's booklet covers information about young people's rights in relation to care and treatment, confidentiality, consent to treatment, Gillick competency, self-advocacy, assertiveness and complaints. As well as showing how these things all work, it contains 10 'Power Tools', most of which can also be used effectively by young people who are not inpatients.

The Toolkit will help give people like you in this situation some confidence if you are feeling concerned about having to become an inpatient in the future.