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ELSEVIER Clinical Skills

Depression: Adolescent Patients - CE

ALERT

Don appropriate personal protective equipment (PPE) based on the patient's signs and symptoms and indications for isolation precautions.

Adolescents with the diagnosis of depression may be at risk for intentional self-harm, suicidal behaviors, or both. Suicide, a potential consequence of depression, is a leading cause of death among adolescents.[2] The Joint Commission has set a goal for organizations to identify patients who are at risk for suicide, which includes those who may have concurrent medical illnesses. Adolescents should be screened for suicidal ideation and risk factors on admission and periodically thereafter, and services or intervention should be provided for those at risk.[7]

OVERVIEW

Depression, sometimes referred to as major depressive disorder or clinical depression, is a serious mood disorder. It is a medical condition considered to be caused by a combination of genetic, biologic, environmental, and psychological factors. Mood disorders are a common diagnosis leading to inpatient stays among adolescents.[10]

Symptoms of depression can range from mild to severe. When severe, depression can alter thoughts, feelings, and behaviors. In adolescents, depression may present somewhat differently than in adults. When asked to describe their mood, adolescents do not commonly use the word "depressed" as adults may. More likely, they use terms such as "trapped," "bored," "nothing matters," "stressed," "things will never get better," and "I feel like giving up."

Health care team members should remember that depression is not feeling blue or having a bad day; it is not a passing disappointment regarding life situations, a personal weakness, or a character flaw. Adolescence is considered a tumultuous time, so attention should be paid to signals that may indicate depression rather than the normal challenges related to navigating developmental milestones.

Signs and symptoms of depression in adolescents may include:[1]

- Sadness, anxiety, and aggressive behaviors (commonly)
- Lack of energy and a constant tired feeling
- Complaints of feeling bored; loss of interest in usual activities
- Withdrawal from friends and family
- Low self-esteem and self-deprecating statements
- Inability to concentrate, which leads to decline in school performance
- Significant change in eating habits (decreased or increased)
- Significant change in sleep patterns (inability to fall asleep, stay asleep, or get up in the morning)
- Lack of care about appearance and personal hygiene
- Aches and pains (with no known medical cause)
- Pessimism and indifference (not caring about anything in the present or future)
- Thoughts of death or suicide

Depression is not a state from which a person can suddenly break free. Depression can become a chronic illness that tends to relapse. Both adolescent boys and girls with depression are at increased risk for suicide. Suicide is a leading cause of death for adolescents and young adults.[2] Girls are more likely to attempt suicide, but boys are far more likely to die by suicide. According to guidelines from the U.S. Preventive Services Task

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Force, screening adolescents for depression should occur in clinical practices that have systems to accurately diagnose the adolescent, provide treatment options, and follow up on the care provided.[8,11]

Two treatment options that have proven successful for adolescents with depression are medications and psychotherapy.[4] Research has shown that some selective serotonin reuptake inhibitor (SSRI) antidepressants are effective in relieving symptoms of moderate to severe depression in adolescents.[4,9] The U.S. National Institute of Mental Health funded the Treatment of Adolescent Depression Study (TADS), which compared therapy with the antidepressant fluoxetine to cognitive-behavioral therapy and a combination of the two. Researchers found that combination therapy with fluoxetine and cognitive-behavioral therapy was nearly twice as effective at relieving depression as psychotherapy alone.[5]

Adolescents who have recently started taking antidepressant medications must be monitored for adverse reactions. The U.S. Food and Drug Administration released a black box warning for SSRIs, stating that this class of medication causes an increase in suicidal thinking when compared with placebo.[3,12] Health care team members should carefully monitor adolescents beginning treatment with an SSRI for suicide ideation. Warning signs include new or worsening symptoms of agitation, irritability, and anger. Unusual changes in behaviors are also signals that the team member should report immediately to the mental health practitioner.

An adolescent's culture may affect his or her willingness to articulate feelings and thoughts to someone else or to seek care from a health care provider. To facilitate communication and cooperation, the treatment team (nurses, practitioners, and therapists) must develop a trusting relationship with the adolescent and family. In some cultures, mental illness is unacceptable, which makes an admission of symptoms or diagnosis less likely. Certain cultures may incorporate practices such as herbs, yoga, meditation, or acupuncture as treatment for depression. The health care team member should use culturally sensitive language to describe the cause of depressive symptoms and related treatment.

EDUCATION

- Provide developmentally and culturally appropriate education based on the desire for knowledge, readiness to learn, and overall neurologic and psychosocial state.
- Inform the adolescent and family about depression and treatment.
  - Depression is an illness caused by multiple factors.
  - Depression is treatable with psychotherapy or medication or both.
- Instruct the adolescent and family regarding medication therapy for depression.
  - Describe the potential adverse effects of prescribed medication.
  - Tell the adolescent and family that after starting therapy with an antidepressant or changing the dose, the prescribing practitioner will closely monitor the adolescent for suicidality, worsening of symptoms, and behavioral changes.[3]
  - Adolescents taking antidepressants should be closely monitored for any sign that the depression is getting worse. Warning signs that should be reported to the mental health practitioner include new or worsening symptoms of agitation, irritability, and anger as well as unusual changes in behaviors.
  - Occasionally, the first antidepressant prescribed is not effective, but another medication in the same class may be effective. Adolescents should be told not to give up. The adolescent may take antidepressant medication for a period before feeling the effect.[9] Patience and continued adherence are vital. Frequently, physical signs of depression are the first to remit (e.g., sleep improves before mood elevates).

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- Ensure that the adolescent and family understand the danger of stopping antidepressant medication therapy abruptly. Symptoms can return rapidly and may increase the risk of self-harm and suicide. Medication should be changed or discontinued only under the direction of a mental health practitioner.
- Encourage questions and answer them as they arise.

ASSESSMENT

1. Perform hand hygiene and don PPE as indicated for needed isolation precautions.
2. Introduce yourself to the patient.
3. Verify the correct adolescent using two identifiers.
4. Screen the adolescent for risk factors for depression.

a. Family history of depression
b. Early negative experiences or trauma
c. Exposure to stress, neglect, or abuse
d. Feeling alienated from parents or guardians
e. History of being bullied by peers
f. Substance use or abuse
g. Recent loss, such as a breakup of a romantic relationship or loss of a pet
h. History of self-harm behaviors, suicidal ideation, or suicide attempt

5. Assess the adolescent for medical illnesses with symptoms that may overlap depressive symptoms.
6. Assess the patient for suicidal or homicidal ideation or thoughts of self-harm. Use an organization-approved standardized tool for suicide assessment.[7]
7. Assess the skin for self-mutilation scars from cuts, bites, or burns.
8. Ask the adolescent about his or her sleeping, eating, and self-care habits.

> Rationale: Sleeping, eating, and self-care habits often deteriorate during a depressive episode.

9. Assess the adolescent's nutritional and hydration status.
10. Compare collateral information from the family with the adolescent's perceptions of depression symptoms. Interview family members or close friends separately from the adolescent.

> Rationale: Interviewing family members or close friends separately allows for uninhibited discussion.

11. Assess the need for a psychiatric practitioner consult and seek a consult as appropriate.

STRATEGIES

1. Perform hand hygiene and don appropriate PPE based on the patient's signs and symptoms and indications for isolation precautions.
2. Verify the correct patient using two identifiers
3. Explain the strategies to the patient and family and ensure that the patient agrees to treatment.
4. Establish a rapport with the adolescent and family members.

> Rationale: Rapport builds trust, shows respect, and enables the health care team member to engage others in a cooperative working relationship.[6]

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5. Treat the adolescent with courtesy by speaking to him or her directly and respectfully. Do not communicate through the adolescent's parents.
6. Use matter-of-fact language and eye contact when addressing the adolescent. Ask questions in a clear, direct manner.
7. Create a plan of care.

a. Actively engage the adolescent and family, if appropriate. Keep the adolescent and family involved and informed as much as possible.
b. Ensure that interventions are developmentally and culturally appropriate.
c. Incorporate recommendations from a mental health consult, if available, and outpatient mental health practitioner, if appropriate.

8. Offer emotional support by demonstrating active listening, using a nonjudgmental approach, and validating feelings. Avoid lecturing, giving unwanted advice, or sharing personal experiences.

> Rationale: Demonstrating active listening, using a nonjudgmental approach, and validating feelings are strategies that build rapport with the adolescent by reinforcing the health care team member's credibility.

9. If the adolescent is at risk for self-harm or suicide, observe him or her closely for self-harm behaviors and suicidal ideation.

> Rationale: Health care team members are responsible for preventing harm and suicide attempts by removing opportunities for adolescents to hurt themselves or others.
>
> **Provide close, continuous observation and ensure appropriate precautions as needed. Always take suicidal or self-harm statements from adolescents seriously.**

10. Review the adolescent's medical illnesses and current medications.

> Rationale: Some illnesses can mimic depression (e.g., hypothyroidism) or commonly coexist with depression (e.g., diabetes mellitus).

11. Determine whether the adolescent has experienced any symptoms that may indicate depression.

a. A persistent sad or irritable mood or aggressive behaviors
b. A loss of interest in activities formerly enjoyed
c. A significant change in appetite or body weight
d. Difficulty sleeping or oversleeping
e. Psychomotor agitation or retardation
f. Decreased energy or activity
g. Feelings of worthlessness or inappropriate guilt
h. Difficulty concentrating and making decisions
i. Sadness or sense of hopelessness
j. Recurrent thoughts of death or suicide

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12. Assess the family history for depression, especially in parents and siblings.

Rationale: A family history of depression increases the risk of depression because of genetic and environmental factors.

13. Encourage problem solving by helping the adolescent identify his or her strengths, coping skills, interests, and goals.

Rationale: Encouraging problem solving helps the adolescent focus on positive ways to manage depression.

14. Engage the adolescent and family in problem-solving behaviors.

Rationale: Modeling behaviors that promote positive outcomes and improve problem-solving abilities provides options and empowers others to make changes. Involving family members in the problem-solving process also discourages blaming and other antagonistic behaviors.

15. Avoid minimizing or dismissing the adolescent's stressors, such as a relationship breakup.

Rationale: The stressors of adolescence may be temporary, but the health care team member should not minimize the adolescent's upset feelings.

16. Ask the adolescent what would make his or her stay in the unit easier and make arrangements, if possible, according to the organization's practice.

Rationale: Providing distraction, comfort, or familiar items reinforces the positive relationship between the health care team member and the adolescent and may reduce symptoms of depression.

17. Keep in mind that a chronic or serious medical illness (e.g., diabetes mellitus) may be socially devastating to the adolescent. Engage him or her in a conversation about the illness to obtain a better understanding of its impact.[8]

Rationale: Adolescents commonly have difficulty dealing with illnesses or injuries that make them different from their peers. In some cases, the adolescent may become resistant to managing his or her medical illness. The adolescent may also avoid school or social situations and become self-conscious about differences. A chronic medical illness may put an adolescent at risk of developing depression.

18. Keep in mind that adolescents who are excessively angry or anxious may be dealing with underlying depression.

Rationale: Many adolescents who are depressed use angry behaviors to push others away. Anxiety disorders can increase the risk of depression.

19. Encourage good health habits related to sleep, nutrition, and physical health. If needed, help the adolescent maintain or achieve balanced nutrition and hydration, adequate sleep, and appropriate levels of physical activity while in the unit.

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Rationale: Individuals with depression commonly experience changes in sleep, eating, and self-care habits. Exercise and physical activity can have a positive effect on a patient's mood and reduce symptoms of depression.[13]

20. Discuss with the adolescent the risks of substance abuse on mental health and stability.
21. Avoid taking sides in situations of conflict between the adolescent and the parents.

Rationale: Taking sides reinforces power struggles rather than assisting with solving the problem.

22. Monitor visits from family or friends if an indication of neglect or abuse is present.

Rationale: Many depressed adolescents have supportive, loving families and friends. However, if neglect or abuse is suspected by the health care team (or reported by the adolescent), visits should be monitored.

Report suspected abuse to the appropriate agency per regulation and the organization's practice.

23. Communicate information to other members of the health care team.
24. As appropriate before discharge, arrange follow-up outpatient care to manage depression.
25. If the adolescent starts antidepressant medication therapy, provide detailed education to the adolescent and family regarding the dosing, adverse effects, and expected results.
26. Remove PPE and perform hand hygiene.
27. Document the strategies in the adolescent's record.

REASSESSMENT

1. If the adolescent has risk factors or a positive screen for depression, provide ongoing reassessments to check his or her response to interventions and to modify the interventions as appropriate.
2. If medication therapy is initiated, monitor the adolescent for adverse effects and advise the practitioner accordingly.
3. Closely monitor an adolescent taking SSRIs for suicidality, especially early in treatment.
4. Reassess the adolescent for thoughts of harming self.
5. Reevaluate the adolescent's ability to maintain balanced nutrition and hydration, adequate sleep, and appropriate levels of physical activity.
6. Reevaluate the adolescent's ability to use coping and problem-solving skills.
7. Reassess the adolescent's and family's understanding of and agreement with the plan of care.
8. Assess, treat, and reassess pain.

EXPECTED OUTCOMES

- Trusting relationship between health care team member and adolescent is established.
- Adolescent can state his or her stressors.
- Depression is identified.
- All medical illnesses are managed appropriately.
- Adolescent can identify strengths, coping skills, and goals.
- Adolescent can problem solve more effectively.
- Adolescent is referred for outpatient care if required.

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- Family and adolescent understand education regarding depression and treatment.
- Community referrals are initiated if required.
- Safety is maintained, including absence of self-harm behaviors.

UNEXPECTED OUTCOMES

- Adolescent exhibits self-harm behaviors.
- Adolescent's engagement in self-harm leads to life-threatening situation or death.
- Adolescent is unwilling to engage in treatment.
- Adolescent is unable to identify strengths, coping skills, or goals.
- Adolescent's mental or physical condition deteriorates.
- Family does not support adolescent's care plan.

DOCUMENTATION

- Assessment findings
- Plan of care
- Interventions and strategies, including adolescent response
- Level of cooperation with care plan
- Self-harm or suicidal statements
- Change in medical or psychological status
- Difficulties related to sleep, nutrition, or self-care
- Adolescent's response to medication, including adverse reactions
- Referrals to mental health practitioners
- Education
- Unexpected outcomes and related interventions

REFERENCES

1. American Psychiatric Association (APA). (2013). Depressive disorders. In *DSM-5 Diagnostic and statistical manual of mental disorders* (5th ed., pp. 155-188). Washington, DC: Author. (classic reference)* (Level VII)
2. Centers for Disease Control and Prevention (CDC). (2020). WISQARS™: Fatal injury reports, national, regional and state, 1981 - 2018. Retrieved April 1, 2020, from https://webappa.cdc.gov/sasweb/ncipc/mortrate.html (Level VII)
3. Centers for Medicare & Medicaid Services (CMS). (2015). Antidepressant medications: U.S. Food and Drug Administration-approved indications and dosages for use in pediatric patients. Retrieved April 1, 2020, from https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Pharmacy-Education-Materials/Downloads/ad-pediatric-dosingchart11-14.pdf (Level VII)
4. Cheung, A.H. and others. (2018). Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and ongoing management. *Pediatrics, 141*(3). doi:10.1542/peds.2017-4082 (Level VII)
5. Foster, S. and others. (2019). Estimating patient-specific treatment advantages in the 'Treatment for Adolescents with Depression Study.' *Journal of Psychiatric Research, 112*, 61-70. doi:10.1016/j.jpsychires.2019.02.021 (Level VI)
6. Freira, S. and others. (2017). Effect of motivational interviewing on depression scale scores of adolescents with obesity and overweight. *Psychiatry Research, 252,* 340-345. doi:10.1016/j.psychres.2017.03.020 (Level VI)
7. Joint Commission, The. (2020). National patient safety goals: Hospital accreditation program. Retrieved April 1, 2020, from https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/npsg_chapter_hap_jan2020.pdf (Level VII)

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8. Leslie, K.R., Chike-Harris, K. (2018). Patient-administered screening tool may improve detection and diagnosis of depression among adolescents. *Clinical Pediatrics, 57*(4), 457-460. doi:10.1177/0009922817730343
9. Locher, C. and others. (2017). Efficacy and safety of selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, and placebo for common psychiatric disorders among children and adolescents: A systematic review and meta-analysis. *JAMA Psychiatry*, *74*(10), 1011-1020. doi:10.1001/jamapsychiatry.2017.2432 (Level I)
10. Lu, W. (2019). Adolescent depression: National trends, risk factors, and healthcare disparities. *American Journal of Health Behavior, 43*(1), 181-194. doi:10.5993/AJHB.43.1.15 (Level VI)
11. Siu, A.L. and other. (2016). Screening for depression in children and adolescents: U.S. preventive services task force recommendation statement. Retrieved April 1, 2020, from https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-children-and-adolescents-screening (Level VII)
12. Spielmans, G.I., Spence-Sing, T., Parry, P. (2020). Duty to warn: Antidepressant black box suicidality warning is empirically justified. *Frontiers in psychiatry*, *11*, 18. doi:10.3389/fpsyt.2020.00018
13. Wegner, M. and others. (2020). Systematic review of meta-analyses: Exercise effects on depression in children and adolescents. *Frontiers in Psychiatry*, *11*, 81. doi:10.3389/fpsyt.2020.00081 (Level I)

ADDITIONAL READINGS

Zhang, Y. and others. (2018). Antidepressants for depressive disorder in children and adolescents: A database of randomised controlled trials. *BMC Psychiatry, 18*(1), 162. doi:10.1186/s12888-018-1749-0

*In these skills, a "classic" reference is a widely cited, standard work of established excellence that significantly affects current practice and may also represent the foundational research for practice.

Elsevier Skills Levels of Evidence

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- Level V - Descriptive or qualitative studies
- Level VI - Single descriptive or qualitative study
- Level VII - Authority opinion or expert committee reports

Supplies

- Gloves and PPE, as indicated

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