The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 11, Issue 3, July- September, 2023
DIP: 18.01.206.20231103, DOI: 10.25215/1103.206
https://www.ijip.in

Research Paper

Psychiatric Social Worker Approach to Identifying and Treating Depression among Teenagers

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ABSTRACT

In recent past years many research has been proved that by age 18, about 20% of our teenagers will have had at least one major depressive episode, with boys are substantially higher risk. Major depressive episodes in teenagers last an average of 6 to 9 months, 6% to 10% of depressed teenagers have protracted episodes, and the probability of recurrence within 5 years is about 70%. Given that the lack of awareness about depression in India people are as not likely to seek help in primary stage. Lack of assistance when person is seeking help or can come out from the stage it severely converts mental disorder and person also can be suicidal. So, the late assistance in depression can cause a serious mental health issue. Primary care should have been given to depressed person as soon as possible.

Keywords: *Psychiatric Social Worker, Depression, Teenagers, Treatment*

Psychiatric social worker is a specialized in playing ground work role in society. Psychiatric social work that involves supporting and providing multiple therapies and coordinating the care of people who are severely the care of people who are severely mentally ill and who require hospitalization or other types of intensive psychiatric help.

Psychiatric Social workers in this challenging and demanding field must work closely with individuals suffering from complex and hard to manage conditions who are in deep emotional distress and or may be a danger to themselves or others, including psychosocial and risk assessments, individualized and group psychotherapy, crisis intervention and support, care coordination, and discharge planning services. Psychiatric social workers are employed in a variety of settings, ranging from intensive inpatient wards to outpatient psychiatric clinics and early detection of depression.

Objectives

- *Understand the importance of diagnosing and treating depression in teenagers.*
- *Identify the symptoms of depression in teenage and the difference between depression and normal teenager moods.*
- *Identify suicidal risk in a depressed adolescent.*

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Received: January 24, 2023; Revision Received: August 13, 2023; Accepted: August 16, 2023

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- *Understand when a specialty consultation is needed.*
- *Understand what effective treatments are available.*

CASE HISTORY

Mahi, aged 18 years, was living in one small place and was carrying miserable behaviour, Psychiatric Social worker during their home visit identified her in severe level of depression. She was good in good health and has had no notable medical illnesses in the past year. However, Mahi complains of difficulty sleeping in the past many months and of frequently being tired. PSW asked her parents for a few minutes alone to discuss about her daughter recent behaviour changing pattern. They state that "Mahi has been much more irritable than her usual self" and that "her teachers have been complaining that she doesn't seem to attend to her work lately and her grades are slipping." Mahi's parents remember being an unhappy adolescent herself and asks your advice on how to help her daughter.

When directly questioned, admits to "feeling pretty bad for the last few months, since school began." She concedes that she feels sad and blue most days of the week and believes that she is "a loser." She's been spending more time alone and, despite complaining of chronic boredom, has little energy or desire to engage in recreational activities.

METHODS

Our results come from empirical research and clinical trials, and they are based on literature searches using the MEDLINE and PsychLIT databases. Some recommendations are based on published expert opinions due to the very small body of literature, notably in the area of treatment. We have noted the instances where we consulted an expert.

What does depression look like in adolescents?

In order to be diagnosed with major depressive disorder, an adolescent must exhibit five out of nine distinctive symptoms for at least two weeks, according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Depressed or irritated mood, as well as a generalised lack of enjoyment or interest in once-favourite activities, must be present in at least one of these symptoms. Both are common in many severely depressed adolescent patients. For instance, a depressed adolescent can be irritable, feel down most of the day, quit going out with friends, and appear to lose interest in soccer.

Summary points

- Adolescent depression is prevalent, and primary care mental health professionals such as a Psychiatric social worker, psychologist, and doctor are frequently in a position to initially recognise the signs.
- Changes in feelings, thoughts, behaviours, and bodily functions are all signs of depression. Depression in adolescents can entail both sad and irritated mood.
- Unlike typical adolescent moods, depression is severe and persistent and interferes with an adolescent's capacity to succeed academically, connect with others, and partake in activities that are suitable for their age. In assessing the risk of suicide, ask straightforward questions about the adolescent's intent, plan, and means.
- Psychotherapy and antidepressant drugs may be helpful treatments; a mix of these is frequently best.
- Giving the teenager and parents information on depression might help families communicate more clearly and make recovery easier.

The symptoms of major depression are more severe in intensity, interfere with social, academic, and recreational activities, and last for months at a time instead of fluctuating like more typical adolescent ups and downs. This is despite the fact that all adolescents experience sadness on occasion, and adolescent angst may be normal and common. 6 Depression is characterised by a slew of physical, emotional, and mental changes that typically deviate from an adolescent's typical demeanour. Some adolescents present with depressive symptoms but do not meet the full criteria for having major depression. Dysthymic disorder is characterized by milder but more persistent symptoms than major depression. In dysthymic disorder, symptoms are present much of the time for at least one year in adolescents (2 years in adults).

Mahi's physician prescribes a low dose of fluoxetine hydrochloride (Prozac), a selective serotonin reuptake inhibitor. In addition, the physician refers Mahi for interpersonal therapy to help her cope with the losses and disappointments of the past year, develop new peer relationships, and reintegrate herself into high school activities. This multifaceted approach will address the physical and psychological symptoms Mahi has been experiencing and provide her with skills she can use to combat future depressive symptoms and interpersonal problems.

How the symptoms of depression affect an individual's life?

Understanding depression is aided by the vulnerability-stress paradigm. The basis of adolescent depression, according to this theory, is a predisposition to depression that is then exacerbated or precipitated by environmental stress. The precise tendency may be influenced by biological and cognitive factors. The interaction between life's stresses and cognitive and biological weaknesses is crucial for understanding adolescent depression.

Depression can be brought on by a string of unfavourable conditions and experiences. Adversity in the adolescent's family, challenges in the classroom, ongoing medical concerns, and loss in their lives can raise risk. Losses like her breakup with a partner and failing to make the track team may act as triggers, as Wanda's past demonstrates. An adolescent may be particularly vulnerable to conditions like asthma, sickle cell anaemia, irritable bowel syndrome, recurrent stomach pain, and diabetes mellitus.

According to cognitive models of depression, the tendency to perceive stressful situations negatively rather than actual stressful events or conditions is what causes and sustains depression. When something bad happens, the depressed adolescent frequently views the cause as stable, internal, and universal. For instance, Mahi claims that she is a "loser" for not making the track squad. This issue is global in scope, internal (her own fault), and stable (unlikely to alter) because it affects everything she does. Vulnerability to depression may result from biologic or genetic factors and lead to numerous biologic changes.

First, studies of family history show that offspring of depressed parents are at high risk for depression[11] and that depressed adolescents have high rates of depression among their family members. Wanda's mother may have been depressed during adolescence. Second, as depressions become more severe, biologic changes may occur, including dysregulation of growth hormone and changes in sleep architecture.

Depression vulnerability may be brought on by biological or genetic causes, which can disrupt several biological processes. First, research on family history indicates that depressed teenagers have high rates of depression among their family members and that

children of depressed parents are at a significant risk for depression. Perhaps Mahi's mother suffered from depression when she was a teenager. Second, as depressions worsen, physiological alterations such growth hormone dysregulation and modifications to sleep architecture may take place.

How should adolescent depression be evaluated?

Clinical evaluation is used to make the depression diagnosis. In addition to physical symptoms, doctors should enquire about changes in an adolescent's moods, feelings, and thoughts, behaviours, daily functioning, and any impairment in that functioning. Additionally, it is necessary to rule out any medical explanations (such as thyroid disease or adrenal insufficiency) or substance abuse as potential causes. The best assessment techniques include reports from parents, guardians, and other external sources in addition to the adolescent's self-report. Youths, on the other hand, frequently report their internal experiences, such as their emotions, more accurately.

How do you determine whether to help a suicidal adolescent and when?

Depression is associated with a markedly increased risk of suicide and attempted suicide. About 41% of depressed youths have suicidal ideation, and 21% report a past attempt at suicide. Although many people are concerned that asking directly about suicide may suggest the idea, most depressed youths have suicidal thoughts and are relieved at the opportunity to share them. Unfortunately, adolescents may not volunteer this information unless directly questioned. Often depressed youths have thoughts of death, a desire to die, or a more overt suicidal intention. Asking straightforward, unambiguous questions to assess the risk of suicide is the best strategy. Questions may include “Have you thought that life was not worth living?” “Have you wished you were dead?” “Have you thought about killing yourself?” “What have you thought about doing?” “Have you ever tried to hurt yourself?” or “Have you ever actually tried to kill yourself?” If there is evidence of suicidal thoughts or attempts, it is then critical to establish if the adolescent has the intent, plan, and means to attempt suicide. Questions to ask may include “Are you going to try?” “How would you do it?” and “Do you have a gun (knife, pills)?”

When would one require a speciality consultation?

Adolescent depression is generally caused by various life and mental health issues. It is crucial to screen for comorbid diseases as well as issues with psychosocial functioning and life stress because these extra issues have an impact on management options. A specialist mental health consultation is advised if the primary care physician has any doubts regarding the diagnosis and/or treatment plan. If any of the following conditions exist, primary care physicians should schedule a consultation with a specialist: current or former mania, two previous depressive episodes, persistent depressive disorder, substance dependence or abuse, eating disorder, previous hospitalisation for psychiatric issues, a history of suicide attempts, or concerns about the risk of suicide.

Treatments Effective for Adolescent Depression

Although there is little evidence on the treatment of adolescent depression, recent clinical studies have found effective pharmacologic and psychotherapy approaches. The doctor must also explain the adolescent's symptoms to the family.

Although research has clearly documented the use of antidepressant medication for adults with depression, far fewer studies have examined the use of these agents in adolescents. Selective serotonin reuptake inhibitors are the first choice in medication for depressed

adolescents because of their relatively benign side effects, their safety in overdose, and because they only need to be taken once daily. Both tricyclic antidepressants and monoamine oxidase inhibitors are less efficacious in adolescents, are more lethal in overdose, and are not recommended at this time.

Adolescent depression can be effectively treated with cognitive behavioural therapy. They believe that increasing a young person's capacity for adaptation will help to lessen depression symptoms and their ability to operate in their surroundings. The treatment's cognitive component aims to support teenagers in recognising and interrupting negative or pessimistic assumptions, ideas, and interpretations of events as well as in developing new, more constructive or upbeat ways of thinking. In order to increase the likelihood of receiving positive feedback, the behavioural component emphasises developing positive interactions with others.

Relationship improvement is a focus of interpersonal therapy. The treatment is brief and concentrates on the issues that led to the current depressed episode. Adolescents benefit from its ability to lessen and manage stress. Its capability to lessen depression has been supported by two research.

For choosing when to start with medication, psychotherapy, or a combination of medication and psychotherapy, no clear-cut guidelines have been provided. To assist clinicians in making this choice, we have however included a number of sensible factors. For instance, medication should be taken into account if a teenager lacks cognitive ability, is severely depressed with vegetative symptoms, has experienced two or more episodes of depression, does not seem interested in thinking about issues, has not responded to 8–12 weeks of psychotherapy, or cannot consistently make it to therapy sessions. In contrast, adolescents who dislike taking pills, are afraid of medication, prefer talking about their problems, have complex life stressors that need to be resolved, have contraindications to medication (such as pregnancy or breast-feeding), or have not responded to a sufficient trial of medication should be given psychotherapy as their first option. It might be appropriate to start with both medicine and psychotherapy for some teenagers who have a mix of severe depression, poor cognitive abilities, and complex life circumstances.

Falling grades and a lack of interest are sometimes interpreted by parents as deliberate behaviour since they have limited comprehension of the adolescent's symptoms. The doctor can aid parents in helping their kid recover, monitor symptoms, and support continued care by educating them on the signs, causes, and treatments of depression. 3 Different families have different levels of openness to the idea that their child might have a psychological or mental issue. Some families may be more comfortable with a pharmaceutical intervention because they are more open to a medical model that views the depressive symptoms as a component of a disease for personal and/or cultural reasons. Other families could find psychotherapy to be a more agreeable solution and a cognitive explanation more digestible. Primary care doctors may also observe that parents of depressed adolescents may feel guilty or blamed after learning about the condition, making them reluctant to offers for therapies. Appropriate information of depression and its potential causes may aid in assuaging these worries.

Symptoms of major depressive disorder in adolescents

- Anger or depression;
- Loss of enjoyment in once-enjoyed activities;

- Significant weight loss or gain when not dieting;
- An increase or decrease in appetite;
- Insomnia or hypersomnia;
- Visible slowing of movements and speech or increased agitation;
- Fatigue;
- Feelings of worthlessness or excessive and/or inappropriate guilt;
- Difficulty concentrating and/or making decisions;
- Repeated thoughts of death or suicide or a suicide at an early

Symptoms of dysthymic disorder in adolescents

It's crucial to focus on the symptoms of depression that are less likely to coexist with physical diseases in teenagers who already have them, such as feelings of shame, worthlessness, and hopelessness. It could be challenging to distinguish between depression and the sickness when it comes to changes in food, sleep habits, and level of weariness. Depressed or irritable mood must be present for most of the day, more days than not, for at least 1 year.

In addition, 2 of the following 6 symptoms must be present:

- Poor appetite or overeating
- Insomnia or hypersomnia
- Low energy of fatigue
- Low self-esteem
- Poor concentration or difficulty making decisions
- Feelings of hopelessness

During this time, the adolescent has never been without the depressive symptoms for more than 2 months at a time but does not meet criteria for a major depressive episode.

Having assessed thoughts of death, the intention to die, plans for an attempt, the means to commit suicide, and the availability of support, the physician must estimate the degree of risk and make choices for managing the patient's risk of suicide. First, although thoughts of death or thinking of suicide in vague terms suggests a low risk, such symptoms indicate a need for both immediate intervention and close monitoring (because suicidal risk can increase).

Second, if safety can be maintained by involving parents and other support networks, emergency treatment may not be required when the adolescent confesses having a plan or means but no intent. The adolescent must be referred for counselling, parents must be present, and weapons like rifles must be put away.

However, if the adolescent lacks a loving family, has access to deadly weapons, or has additional risk factors (such as a history of suicidal thoughts or family history). suicide, exposure to suicide recently, substance abuse, bipolar disorder, mixed state, or extreme stress), more intense interventions are required, and the adolescent needs to consult a mental health professional.

The danger of suicide is highest when the adolescent has intention, a plan, and the tools to carry it out. Such youth require quick assistance, and it may be necessary to receive mental

emergency care. 3 No matter the risk, follow-up care is necessary to address the issues that led to the adolescent's suicidal thoughts.

Empirically supported treatment options

Selective serotonin reuptake inhibitors Alters dysfunctional neurotransmitter systems.

Cognitive behavioural therapy Monitors and changes dysfunctional ways of thinking.

Interpersonal therapy Improves interpersonal skills and problem-solving abilities.

Counselling Session Via Professional Psychiatric Social Worker.

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Acknowledgement

The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author(s) declared no conflict of interest.

How to cite this article: Tyagi, P. & Chowdhary, R. (2023). Psychiatric Social Worker Approach to Identifying and Treating Depression among Teenagers. *International Journal of Indian Psychology*, *11(3)*, 2196-2203. DIP:18.01.206.20231103, DOI:10.25215/1103.206