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The specific features of adolescent depression – from developmental reaction to clinical syndrome

Depression belongs to the most common mental disorders of young people. Yet, its analysis has given rise to many controversies among specialists. One of the crucial raised issues is the question whether it is justified to apply the diagnosis of depression in this age group, considering the fact that intrapsychic mechanisms in adolescents are not yet mature. The theoretical problem arises: to what degree adolescent depression ought to be considered a clinical disorder, rather than a specific developmental reaction. In the present paper, the attempt has been undertaken to tackle the issue. It has been found that the diagnosis of adolescent depression cannot rely on clear-cut diagnostic criteria. Instead, it should rely on clinical assessment of an individual patient.

Keywords: *depression, adolescence, diagnosis*

Introduction

The concept of depression has not been finally and precisely defined in psychological literature. It is often understood as the condition of feeling low and sadness. The concept of depression is often used interchangeably with mourning. It is also applied to one of two categories of psychic disorders: unipolar or bipolar depression. Moreover, it can be revealed in various forms – from the expression of sadness, through dysphoric mood, up to a number of behaviors such as psychomotor agitation, intended to disguise the true emotional condition.

The study of depression observed in adults has relied on numerous theoretical analyzes and empirical research studies. On the other hand, in the case of youth and children the concept of depression has given rise to much controversy. The theoretical disputes have been related to the diagnosis, epidemiology, aetiology, and the methods of treatment. Scholarly interest in the adolescent depression was developed as a secondary line of research, in relation to adult depression study. It has been so in spite of the fact that this condition belongs to the most frequently diagnosed psychic disorders in this age group. Recent studies have even shown the growing tendency of youth depression occurrence, which has been related also to current social circumstances (Jaklewicz *et al*., 2001). What is more, it has been increasingly often observed that adolescent depression displays a strong tendency to evolve into a chronic condition (Namysłowska, Bronowska, 2001).

Pursuant to DSM classification, the crucial symptoms of adult depression include the following: depressed mood, diminished interest or pleasure in all, or almost all activities, weight loss, insomnia or hypersomnia, psychomotor agitation or retardation, loss of energy, feeling of worthlessness or inappropriate guilt, diminished ability to think or concentrate, recurrent thoughts of death, recurrent suicide attempt or specific plan for committing suicide (DSM-IV, 1994). According to ICD-10 classification, adult depression is shown by the following symptoms: depressed mood, reduced life energy, a decreased activity, a reduced feeling of pleasure, a reduction of the field of personal interest, lower attention focussing, fatigue, sleep disorders – in particular waking up early, reduced appetite, low self-evaluation, ideas of guilt and worthlessness, libido loss.

Adolescent depression

Pataki and Carison (1995) have observed that in the case of youth and children, depression becomes more widespread in line with age progression. Also its clinical picture alters. In the case of children, depression usually is revealed through somatic disturbances such as headache or stomach-ache, hearing hallucinations, psychomotor

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agitation, separation fears or phobias. In the case of older children and adolescents more frequent symptoms include: emotional instability, delusions, anhedonia, the feeling of hopelessness or a decrease in activity. In the group of teenagers the most typical symptoms include insomnia, alcohol or drug abuse. Such depression symptoms as insomnia, depressed feeling or concentration difficulties are equally frequent in all age groups. Also the suicidal thoughts are reported with similar frequency. In the case of younger children, the thoughts only appear, while the depressed adolescents often display also suicidal attempts. Adolescents are also more prone to express verbally depressed mood.

The attempts at classification of adolescent depression on the basis of adult criteria encounter significant difficulties. The reasons of these difficulties should be sought in the entanglement of a young person's experience in the problems specific for adolescence. The crucial ones include the following: the appearance of a sexual impulse and difficulties related to its integration, emotional fluctuations induced both by endocrinological developments and psycho-social changes, alterations in self-image, and particularly the image of one's body, the comparison of past self-presentations with current possibilities, the establishment of new relations with adults essentially, but also in peer groups. All the above aspects have resulted in the fact that the presentation of the clinical syndroms of adolescent depression (and therefore also its diagnosis) have encountered many hurdles. At this point, the question should be formulated (to be re-iterated later on in this paper) to what extent the adolescent depression should be treated as a nosologic disease, rather than a specific developmental reaction.

Kępiński (1974) in his monograph devoted to melancholy indicated the specific character of adolescent depression. He proposed to distinguish four forms of such depression. The first of them is the apathetic-aboulic form. In this category, the most characteristic features include: difficulties in coping with crisis situations, incapacity to mobilise psychic forces necessary for envisaged effort, lower results in school education, neglect in personal outlook, boredom interrupted by drinking bouts, sexual excesses or hooligan offences. The second category is the mutinous one. It can be recognised in acute forms of rebellion, domination of negative feelings, difficulties in self-control. This condition may lead to violent impulsive reactions. Attempts of self-mutilation or suicide have been observed. In the third category, consisting in resignation, depressed persons experience a lack of confidence in their possibilities, resulting in the discrepancy between their dreams and the existing reality as well as actual capacities. In result, the future seems grey, boring and uninteresting. The final category is the unstable form, in which alongside the emotional change-ability, the depressed person experiences the feeling of no sense in existence, emotional emptiness, an inferiority complex, interspersed with periods of elevated emotions.

The more recent attempts at the analysis of adolescent depression, relying on clinical research, include the categorisation introduced by Bomba (1981). He distinguished simple adolescent depression, which may be additionally revealed in three different forms. The pure depression displays both the reduced emotional mood and stimulation, the indefinite fear, and apprehension of the future. In adolescent depression with resignation, alongside the above-mentioned symptoms, there appears the educational deficiency, feeling of life being senseless, suicidal tendencies and attempts. The adolescent depression with resignation features additionally shows the symptoms of emotional instability and auto-destructive behaviour disorders, and in adolescent hypochondriac depression – the somatically revealed fear and hypochondriac focussing on the individual's body.

Relying on the above and my own clinical experience, the following features seem to be most characteristic of adolescent depression: prolonged fatigue and boredom, difficulties in studying, the feeling of guilt and victimisation, suicidal thoughts and attempts, somatic disturbances and delinquent behavior. Usually, the former two provide the reason why the social environment of the youth (mainly parents) seeks medical advice. The above description shows also that depression may be hidden under behavior patterns that may be qualified as conduct disorders rather than depression. This observation leads us to the concept that needs to be mentioned in the analysis of youth depression, i.e. the disguised depression. In the case of adolescents, this form of depression occurs particularly frequently. For a long time, the observed symptoms may seem very distant from those that are usually associated with depression.

The above analysis relied on the assumption that a category called adolescent depression exists. Yet, it seems that this assumption is far from obvious, considering the highly differentiated clinical picture. When various theoretical constructions are used to study this problem, the results are often inconsistent.

Theoretical frameworks of depression

The most frequently applied concepts in the literature devoted to depression study are the following: psychoanalytic, cognitive, behavioral and bio-chemical models. Though highly differentiated, all psychoanalytic constructions focus on the really experienced or imaginary loss. In the classic Freudian concepts, it is the object of love that was lost. If the process of mourning has been disturbed, or has been incomplete, the bereaved person will often develop depression symptoms. Within this theoretical

approach it is quite possible to assume the existence of both childhood and adolescent depression. According to another Freudian concept, depression results from the conflict between *ego* and *superego*. It occurs when inappropriate aspects of the object of love are internalised by *ego*. Depression may also be caused by the severe and penalising *superego*. Finally, depression may ensue as defensive measure of *ego* suffering from low self-evaluation. None of these concepts provide a clear answer to the question whether depression can be diagnosed in childhood and adolescence. Negative answer to this question refers to views emphasizing insufficiently developed intrapsychic mechanisms. An affirmative answer can be corroborated by observations made by psychoanalysts themselves. Bowlby diagnosed depression in cases of children deprived of motherly care. Spitz defined it as anaclitic depression.

The cognitive model includes first-of-all Seligman's theory of learned helplessness and Beck's theory of cognitive disorders. In his experiments Seligman (1975) subjected animals to training of learned helplessness. The animals were kept in a cage where they had no possible influence upon the experienced negative stimuli. The same animals were later placed in another cage where they could prevent such adverse events. Yet, these animals were much slower in learning effective behavior when compared to control group animals that had not been subjected previously to helplessness training. The effects of such a training, defined as learned helplessness deficits consist of three elements: motivation deficit (revealed in passivity or slowdown of activities), cognitive deficit (consisting in association troubles of response and reinforcement), and the emotional deficit (leading to depression). Beck (1967/1991) emphasised disorders of the following three spheres of cognitive functions displayed by depressed persons: the perception of oneself, the world and the future. The depressed persons either exaggerate or wrongly interpret the experienced events, so that they corroborate the negative image of oneself, the environment and the envisaged future.

The cognitive models fail to provide a clear answer to the question about the existence of the category of childhood and adolescent depression. Some researchers believe that learned helplessness is related to motivation processes more than to depression as such. The application of Beck's concept to children was not buttressed by sufficient empirical corroboration.

In the behavioural perspective, depression is understood as a lack of positive reinforcements. This situation occurs when activities undertaken by an individual provide no pleasure. It relates also to social situations where consequences of depression consist in communication deficits, which may in turn stimulate depression. This model has been criticised for insufficient inclusion of the psychological components of depression. Yet, it can be useful in explaining childhood depression.

Finally, the bio-chemical models focus on hormone distribution disturbances in the case of depressed persons. This model has given rise to a number of studies corroborating the appearance of childhood and adolescent depression.

Studies aiming at the systematisation of problems experienced by families of depressed patients have also been carried out. Bomba *et al*. (1986) observe that families of depressed adolescents showed serious psychic trauma, including the natural or suicidal death of a parent, emigration of parents leaving the offspring behind, family dissolution, the child's placement in an institution, long-term stressful situations such as in-family conflicts, alcoholism, or inadequate parental attitudes. These studies may corroborate the experience of various losses suffered by adolescents, contributing to the development of depression, when it assumed that such losses provide a significant etiological factor. Of course, the question appears why not every person who experienced a loss develops depression. The answer could be provided by studies over the methods of bereavement coping. The preservation of the feeling of control over one's life, or at least some aspects of it, may reduce the effects of the learned hopelessness training defined by Seligman.

Diagnostic problems

The authors critical of diagnosing depression in this age group quote the non-existence of intra-psychic, cognitive or emotional mechanisms contributing to development of clinical depression. Another line of argumentation relies on the observation of adolescents. In this age group, depression can be diagnosed more frequently than in any other. Thus, according to above the diagnosis of adolescent depression should either be forlorn or else considered a developmental reaction. On the other hand, clinicians recognising the appearance of childhood and adolescence depression define it as a set of symptoms contributing to a clinical syndrome. It is emphasized that the depression episode is different in case of children and adolescents compared to adults. It is more often revealed as disguised depression, which is related to the developmentally conditioned impossibility of verbal or affective expression of experience, found in case of adults.

As mentioned above, adolescent depression can be seen as a specific developmental reaction. Kępiński (1974) claimed that adolescent depression was a relatively frequent event. Yet, its development in this stage of life is specific. Usually it lasts shorter and its psycho-pathological picture is different. Kępiński sought the sources of adolescent depression in biological re-arrangement of the organism, leading to unrest, aggression, undefined hopes, the desire

to test personal capacities or rebellion. It is typical then to experience an emotional chaos and sudden mood changes. Depression may also be related to the necessity of coping with new roles and related social requirements. One of the crucial roles may be related to the individual's gender.

Bomba and Kurzydło (1990) referring to Kępiński's views, relate their definition of adolescent depression essentially to the psycho-endocrinological crisis of puberty. Yet, in research covering almost fifteen hundred families with adolescent phase offspring, no significant changes in biological development were found between depressed individuals and the control group of individuals free of depression symptoms. The only (statistically insignificant) difference consisted in the fact that puberty features were observed earlier by parents in the depressed youth group. It is worth noticing that research on medically untreated population of the youth showed that 31.65% displayed significant depression features (42.41% of girls and 22.0% of boys) (Bomba, 1988).

These findings corroborate the propositions that depression can be considered as a specific developmental reaction to the loss experience characteristic of this age (emphasized in particular by psychoanalysis), such as a loss of childhood, life safety, the status of a child, etc. It is also crucial for a young individual to confront new social roles, reflecting directly or indirectly biological transformations.

Summary

In the light of above-mentioned dilemmas, related basically to the question whether adolescent depression can be distinguished as a separate category, showing definite symptoms, it is not easy to formulate clearcut conclusions. The basic dilemma is related to the question whether adolescent depression is a clinical syndrome, or else a specific developmental reaction. When facing such disparate clinical picture, it seems unlikely to develop strict diagnostic criteria of adolescent depression. Individual diagnosis must rely on the clinical case analysis, rather than restrictive theoretical criteria.

The following three diagnostic elements seem to play a crucial role: symptoms intensification, length of their duration as well as vulnerability to emotional change and thought mode. The latter seems crucial to me. If the depressed mood and the resultant thinking mode is subject to changes, such depression ought to be classified as developmental reaction, rather than a psychical disorder that is hard to manage.

- Symptom intensity
- Duration time
- Vulnerability to emotional and thinking mode change

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