The mental health of adolescents

Assessment and management

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BACKGROUND
About 15% of the adolescent population suffers a mental health problem. Although a large percentage of these adolescents present to their general practitioner at least once a year, often their mental health problems are not presented or are somatised. Unfortunately, without intervention many of these mental health problems progress into adulthood where they are often more difficult to solve.

OBJECTIVE
This article provides an approach to assessing mental health problems in adolescent patients and outlines management strategies.

DISCUSSION
General practitioners must be skilled in establishing rapport, assessing the problem(s) and either managing or referring on. Assessment of mental health problems in adolescent patients requires a methodical, patient and diligent approach and may require several consulting sessions. Assessment should include identifying the warning symptoms and signs, a medical review, a search for stressors, problems and evidence of emotional distress, and a review of behaviour at home, work/school and with peers. A review needs to be made of the developmental progress from childhood to adulthood, personality development and resilience. Although management may seem daunting, the skills required are usually part of the GP armamentarium and can be adapted to solve the problem, particularly with early intervention, and successful outcomes of the issues identified are mutually rewarding to both GP and patient.

Although rewarding, the treatment of adolescents requires a dedicated attitude to establishing and maintaining rapport, patience and persistence. The incidence of mental health problems of children and adolescents in Australia has been estimated to be about one in 7.[1] Adolescence is a critical time for developing a robust and resilient personality and severe or chronic mental health problems are likely to impede development. Furthermore, there is likelihood that social drugs may be used for relief of symptoms that in turn may aggravate mental health problems.

It is well known that many children and adolescents take their mental illness into adulthood and that early intervention not only preserves normal personality development but can forestall problems later in life.[2,3] There is also good evidence that various treatments can be effective, but the evidence of which modalities can be best utilised in a busy general practice, particularly rural practice, is unproven. Indeed, it is fair to say there is little hard evidence regarding the effectiveness of general practitioners in managing mental health problems in children and adolescents.[4]

Nevertheless, GPs are well placed to use the skills and knowledge they have developed to improve the wellbeing of children and adolescents. Obviously, these skills can be enhanced and made more efficient by further skill training and adapting them to general practice.

Adolescent mental health presentations

Many adolescents have little or no insight into how they feel and even less ability in expressing it. Using the 'correct' words is often helpful. For example, I find very few depressed teenagers but many who are 'cheesed off' or in selected company, 'pissed off', by everything and everybody. I find few adolescents who are suicidal

but many who have thought life is not worth living and had ideas of how they might end it. *Table 1* outlines the differences between features of depression in adolescent and adult patients.

Often the difficulty is determining whether the adolescent's behaviour or perceived problems are normal, exaggerated adolescent behaviour, situational crisis, adjustment disorder, or frank mental illness such as depression, anxiety, obsessional/compulsive disorder, post-traumatic stress disorder or early psychosis. Somatisation and comorbidity may further complicate the presentation. However, the most important goal to be achieved initially is not necessarily to make a diagnosis but to establish rapport and show you are prepared to listen.

Screening

Adult screening instruments are less useful in adolescents.[5,6] However, simple questions such as:

- are you tired?
- do you sleep well?
- are you sometimes sad or cry a lot?
- do you enjoy school/employment?

are sensitive screening questions but with low specificity.

First interview

Until recently, it was rare for teenagers to present with stress or mental health problems *per se* but more often with somatisation such as headaches, insomnia or lethargy. Generally if a teenager is brought in by his or her parents it is a good idea to a get a history of the perceived problems from the parent(s) and then ask the teenager if they mind being seen alone or whether they feel more comfortable with their parent present. In my experience, teenagers speak more freely when parents are absent, particularly when confidentiality and its limits have been carefully explained. The adolescent must be reassured that shared information and feelings are confidential between the adolescent and the doctor. However, it is agreed if the doctor believes the adolescent's life is at risk the doctor has a duty of care to intervene as in other emergency situations. The next step is to take a history from the teenager of the perceived problems from their point of view.

The information from the first interview is secondary to maintaining good rapport but will usually involve:

- the teenager's perception of current problems
- current health status, looking for chronic illness (eg. sinusitis)
- relationships with peers, at school/work and at home
- eliciting symptoms from the 10 areas outlined in *Table 1*
- Mental State Examination, and
- safety.

Table 1. Ten symptoms (questions) that may indicate dysthymia or depression

Symptom	Adult	Adolescent
Insomnia	Interval or initial	Interval or initial (Mum's often deny or normalise)
Lethargy	Abnormally tired	Tired, grumpy, fractious
Depressed mood	Sad, depressed, grumpy	Feel like crying, 'cheesed off' Upset or always being teased School refusal or poor schoolwork
Motivation	Loss of interest in most things	Cannot start homework Unable to complete assignments or work
Memory	Forgetful	Poor school performance
Concentration	Poor	Distractible
Self esteem	Poor	Play victim or bully, loss of resilience
Socialisation	Withdrawn	Few friends, does not play Become loners (look in libraries)
Appetite	Picky	Refuses to eat
Psychosomatic	Palpitations, shortness of breath	Feel awful, abdominal pain School refusal

Figure 1. Useful emergency numbers for adolescents in crisis

While the parent(s) is absent it is useful to obtain a social drug history and sexual history (reinforcing confidentiality) and if necessary give advice about contraception. The mnemonic HEADSS (**h**ome, **e**ducation/**e**mployment, **a**ctivities, **d**rugs and alcohol, **s**exuality, **s**uicide and depression) is a useful reminder of important areas to be considered.

Finally, it is important to give adolescents information about appropriate crisis services. In my case, this is the doctor's rooms or the local hospital where nurses have a set protocol to follow. However, Lifeline, Kids Help Line and suitable family or friends should be added to the list (see *Resources*). A laminated 'business' card with these numbers to be placed in a wallet or purse (*Figure 1*) is useful. Often service clubs will assist local communities with this resource.

The difficult or uncooperative patient

Helping these patients may seem difficult and fruitless. Usually the adolescent has been sent under threat or bribery, by parents, school or judiciary, and frequently will hang the head and at best grunt to any question asked. In these situations I usually get a quick overview from the parent, friend or carer and with the adolescent's permission ask them to leave. The overall aim is to establish rapport so that even if this interview fails the door is open for them to return again. Next I reinforce confidentiality with them. I explain to the adolescent that it appears that they do not want to be there and I am very busy and so the quicker we fulfil mutual obligations to those concerned the sooner we can both move on. Therefore all they need to do is answer 10 questions and we will consider the interview completed. The questions ask about symptoms from the 10 areas listed in *Table 1*. Usually by the time I am halfway through the questions it is obvious to the patient I have some insight into what they feel and what is going on and at that time eye contact is usually obtained and maintained. Frequently, they will want to offer more information and they should be allowed to talk and ask questions and have issues explained. The usual consequence of this approach is the teenager will want to unload everything at that time. Where possible this should be allowed to happen, but if not, always arrange further extended review within a very short period of time to fully discuss the issues. Invite the adolescent to bring a list of questions they would like to raise.

At the conclusion of this interview always determine with the adolescent what should be discussed with their parent(s)/friend or carer and on their return do not move from this agenda. Further questions could be discussed after the next interview with the adolescent's carer, provided permission is given.

A full assessment

A full assessment frequently is not possible on the first interview, often because of time constraints, and further investigation is required.

Medical

A full medical assessment including history, examination and investigations (ie. full blood examination, erythrocyte sedimentation rate, C-reactive protein, urea, electrolytes, liver function tests and thyroid function).

Relationships

History of relationships and behaviour with:

- peers: they should in quick order be able to nominate several very good friends. I look for social activity such as sport or hobbies, and ask about perceived rivals and relationships with the opposite gender
- at school/work: do they enjoy it? Do they have problems?
- at home: look for relationships with parents and siblings and any other problems that may be present.

Academic record

Always ask the adolescent if they enjoy school or work. I look at all school reports from years 1–12 because often there is a salient common theme in the reports. It amazes me that frequently significant undiagnosed learning problems are detected for the first time in adolescents 15–16 years of age! Difficulty at school work requires assessment and recommendation from a qualified educational psychologist. Although this is the province of school guidance officers, they are so sparsely distributed and overloaded that usually it is impossible for them to do a comprehensive assessment, and even if a comprehensive assessment has been recorded, access is usually denied.

Social milieu

This involves looking at the environment in which the adolescent lives: unemployment, parents, single parent, step parent, siblings, indigenous, migrants, access to transport and other resources.

Once an assessment is completed, remedial and support services need to be in place in the shortest time possible. Not infrequently suicidal students who present with suicidal ideation are found to have little mental illness but learning problems associated with very low self esteem. This usually improves rapidly with remedial programs.

Diagnosis and management goals

Although a specific diagnosis may not yet be made the assessment will generate a problem list. Progress toward resolution of these problems can be used as an outcome tool. Frequently resources are not available to manage all child and adolescent mental health problems, and in many rural areas, there is no access to psychiatrists, psychologists, or mental health workers, leaving the GP as the sole provider of mental health services. However, much can be done at the general practice level using techniques GPs use every day. This is particularly true at the early intervention level. This is important as unless problems are dealt with early they have a propensity to escalate to time consuming crisis counselling and difficult referrals. Usually partnerships with parents, teachers, nurses, coaches, police and the GP can be a useful therapeutic alliance. Often a team effort is required, and in rural areas, this has been found to be a helpful substitute for the absence of a

tertiary child and adolescent mental health program.

For some teenagers, interviews for many months may be frustrating for both therapist and patient. However, maintaining rapport, listening, and where necessary directing the process, gives the best chance of a successful outcome. Sometimes progress may appear to be going well until the adolescent appears to 'crash', but again rapport, listening and patience will be rewarded by further improvement. Conversely, a smiling teenager who has appeared to make a miraculous recovery may be a warning that the teenager has planned suicide in the near future.

Management strategies

Some of the techniques used to manage mental health problems are little different from the management of a new diabetic:

- educating regarding the nature of the disease
- motivating to make lifestyle changes
- establishing relationships with allied health workers
- challenging a new approach to diet and exercise
- developing skills to manage their own illness, and
- where necessary, medicating.

Similarly in managing mental health there are several approaches that should be used to resolve the problems identified in the assessment.

Educative approach

- Psycho-education involves an explanation of problems identified, their causes in terms of mental illness or external factors
- Motivational interviewing identifies pathways to resolution or amelioration of the problem.

Relationships

- Narrative therapy looks at evolution of the current problem and the contributors to the current situation. It reviews opportunities and threats and is often a particularly useful strategy for indigenous and ethnic populations
- Family therapy looks at the family dynamics for resolution of stressors and encourages, develops and/or reinforces skills for relationship building
- Interpersonal therapy identifies, evaluates and endeavours to resolve stressors with current significant others in a person's life.

Cognitive behaviour approach

- Behavioural
  - modification is especially important for children prepuberty, and is best coordinated with parents and teachers
  - activity scheduling is useful and often adjunctive to other therapy for adolescents
  - graduated exposure techniques often useful for anxiety and phobias
- Cognitive interventions
  - analysing and challenging and restructuring perceptions of themselves, their attitude to others and life's challenges
  - attention regulation to divert focus from challenging stressors
- Skills training
  - problem solving skills, anger management, stress management, communication training, social skill training, sleep hygiene, and parent training is useful adjunctive training for gaining social confidence and control.

In children, anxiety and dysthymia are commonly seen and here behaviour modification therapy and family therapy are useful approaches. For adolescents, anxiety is often present, and dysthymia and depression become more prominent in the later teenage years; often associated with substance abuse. Here psycho-education, motivational interviewing, cognitive behaviour therapy, and behavioural and cognitive interventions are frequently successful.

Medication

Rarely, if ever, is medication used as sole therapy as it is associated with relapse. However, medication can be a useful adjunctive therapy to gain rapid control initially, and to improve cognition so other therapies can be used successfully.

The most common medications used for major depression, anxiety and obsessive compulsive disorder are selective serotonin reuptake inhibitors (SSRIs). Fluoxetine has been successfully used for depression in children and adolescents[7] and is the recommended SSRI in this age group for use in the general practice setting.[8] However, there does not appear to be any logic that other SSRIs only magically work once a teenager reaches 18 years of age. A particular concern with SSRIs has been the reported increase in suicidal ideation occurring shortly after initiation of therapy.[9] However, there has not been an increase in completed suicides associated with SSRIs in any trials. Remember that recovery from depression by all modalities has been associated with increased suicidal ideation. This has been known for about 200 years.[10] It has been described in most treatment modalities but particularly SSRIs. Some have warned against all antidepressant use.[11] However, antidepressants have been increasingly found to be useful in the

general practice setting and not associated with increased suicide risk.[12]

Starting doses of SSRIs should be low, particularly in younger adolescents and increased gradually until therapeutic level is achieved. Side effects are usually minimal and transient such as nausea, dizziness, sedation or, occasionally, agitation.

Conclusion

Establish rapport, pay attention to body as well as verbal language, promise confidentiality and review. Assessment is a logical review of the adolescent's development and place in the world. Management becomes the resolution of problems identified in the assessment. Resolution of these problems becomes the most useful outcome tool.

Resources

- GP Psych Support 1800 200 588 www.psychsupport.com.au (relevant psychiatrist will respond in 24–48 hours)
- Lifeline 13 11 44 www.lifeline.org.au
- Kids Help Line 1800 551 800 www.kidshelp.com.au
- www.beyondblue.org.au
- www.ybblue.com.au
- www.reachout.com.au
- www.abc.net.au/health/depression
- www.moodgym.anu.edu.au.

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