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TIM'S STORY

MHPN webinars

Adolescent Mental Health: Depression, Suicidality and Cyber-bullying

PSYCHIATRIST REVIEW

Tim has mild depressive symptoms that are worsening. His presentation is quite typical of adolescent depression in child and adolescent psychiatry. However a diagnosis like "depression", whilst important in highlighting Tim needs assistance, risks narrowing and oversimplifying the reality of Tim's experience.

A biopsychosocial formulation that includes a fullish understanding of his developmental history and more recent life context is necessary to address all or at least the most relevant contributing factors.

Over three sessions with Tim, I – like his GP – focussed on developing a therapeutic rapport that led to an alliance in dealing with his problems. Like his GP, I checked his suicidality and Tim reiterated his increasing suicidal ideation but still, thus far, lack of plans or intent. I weaved into conversation with Tim how I had seen many suicidal people and for virtually all there came a time when they were again feeling normal and happy and so glad they had not acted on or succeeded in suicidal behaviour. How suicidal thinking seems to reflect the human brain's problem-solving instinct in looking for an escape when feeling stuck, but in reality nearly everyone who gets stuck and depressed later gets better. Thus having a safety plan is like respecting your future recovered self. Tim found our discussion, talking in generalist terms, helped him externalise the suicidal thoughts and discuss them in a rational context. We identified his maternal uncle and aunt and a male teacher as support people in addition to his GP and private psychologist, plus he also was given emergency after hours numbers.

I enquired about progress of his depressive symptoms and lifestyle. Despite advice from his GP and psychologist Tim was still sleep deprived and up late on the internet, eating a high carb junk food diet and was going to start exercise but always "next week". He still felt humiliated and alienated from his peers since the cyber-bullying.

I enquired about other symptoms. He'd always been a "worrier" and unsure in social situations but never had any panic attacks. Recently he had heard a male voice telling him he was "nothing" and "you're to blame for it", mainly whilst going off to sleep. He denied any other psychotic symptoms, and had no OCD or eating disorder symptoms. He had had episodes at parties where he felt "high" and much more talkative than usual, usually under the influence of alcohol, but these were not sustained and his mother later confirmed he'd never had any rapid tangential speech, grandiose ideas or other manic/hypomanic symptoms. Tim denied nightmares or flashbacks and said he did have unhappy memories of a young age in witnessing his father verbally and physically abusing his mother, also of being "yelled at" a lot by his father when little.

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Tim allowed me to interview his mother in his presence about his early life. She reported a normal full-term pregnancy and birth, Tim being a wanted child whose arrival papered over cracks in the parental marriage for a time. Nonetheless she described his father as "useless" when it came to helping and she felt isolated in the city they'd moved to find work. Her own and her husband's childhoods had both been characterised by alcoholic abusive violent fathers, she had been determined to give a different life to her children. She denied postnatal depression but said she had been over protective and anxious of Tim and her husband had become jealous. This worsened after the birth of Tim's younger sisters and led to eventual domestic violence and an unhappy marriage that eventually ended when Tim was aged 13.

Meanwhile Tim was a clingy child with separation anxiety as a preschooler and often missing school over the years with psychosomatic complaints. Around the age of 10, Tim's father had taken more interest in Tim, taking him to see sporting matches, kicking the footy with him and watching action movies late at night with Tim despite protestations from his wife. Tim was very upset at his parents' separation, initially siding with his father but then later feeling let down as his father's drinking and self absorption worsened.

Speaking alone in the third session Tim confided he had really like the girl who was the subject of his being bullied. He had often been bullied over the years at school and saw himself as less worth than "cool" classmates – a "nothing" like the voice said. I discussed with Tim how voices like this are actually quite common for adolescents who get depressed and who have been yelled at when little and bullied at school. They are like "echoes of verbal abuse from the past" and often occur when sleep deprived, particularly near bedtime, and can be seen as "a bit of a bad dream starting whilst still awake." Given his otherwise rational mental state, they were not a sign that he was going "mad."

I discussed with Tim (and later with he and his mother) how his predicament of feeling depressed had several causes – and addressing each of them should in time see him recover and maybe come out a stronger person than before.

I paraphrased attachment theory and rank theory – how humans are tribal social species and evolution requires socialising, approval by the group and team participation to add survival value for the tribe. Thus socialising is rewarded by the experience of fun, happiness and belonging and participation by positive feeling from praise and approval of others, but conversely painful feelings result from loss of relationships and disapproval by others.

Tim had had a succession of losses – his father, his parents' separation, the ambivalent feelings towards the girl, no longer socialising with his mates and the falling out with "Max". He was suffering from disapproval by his peer group and a particular teacher. No wonder it was depressing him.

Also, using the whiteboard and drawings of the brain, nervous system and body – I described how physiologically evolution has designed us to cope with acute stress but that chronic stress upsets our metabolism (HPA-cortisol axis, sympathetic nervous system, amygdala hyperreactivity, less frontal lobe clear thinking). Chronic inflammation results and this is the latest theory behind depression i.e. a chronic overuse state – thus the need for relaxation and turning on the brain's natural

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parasympathetic nervous system relaxation. This can happen naturally with yawning, sighing and laughing that stimulate the vagus nerve and induce autonomic equilibrium.

Similar to these natural embedded relaxation networks in the nervous system is slow diaphragmatic (yoga like) breathing used in meditation and "mindfulness" practices. In fact elite sports stars, politicians, actors, singers and myself (e.g. in psychiatry exams, daily work) use this technique. Tim was highly sceptical but finally won over by scientific explanation. He watched me "make a fool of myself but a relaxed fool" and copied the technique noting he did "actually feel more relaxed". He agreed to practice it, especially in bed at night.

Similarly, a humorous psychoeducational description of how a regular circadian rhythm, exposure to adequate sunlight (melatonin production to aid sleep, vitamin D which is believed to ward off this depression), exercise, nutritious food and avoiding high calorie low nutrient inflammation inducing junk food that can worsen mood (Tim was familiar with the documentary "Super Size Me"), how Omega3 fish oil supplements can be anti-inflammatory and there is evidence for antidepressants effect – are all important in sustaining normal body and mind functioning and consistent from an evolutionary point of view with how 17-year-old Stone Age lads would have lived.

Tim actually did start watching the Internet/TV with red tinged sunglasses late at night to reduce blue light that was interfering with his circadian rhythm; he would turn the screens off by 11:30 PM, and actually take a book to bed. He found that slow diaphragmatic breathing helped him relax in bed and get to sleep earlier. He agreed to set his alarm to wake by 10 AM at the latest on weekends. He started walking the dog and riding his bike to a friend's house. He spent a little more time outside and took vitamin D supplements after his serum level came back showing severe depletion. He took omega-3 fish oil supplements and ate more fruit and veg and a bit less junk food. Tim's cooperation came fairly easily because therapeutic rapport had been gradually and tactfully established by sensitive engagement with him by his GP and psychologist and I took three sessions, rather than rushing the psychiatric assessment.

The year coordinator, having received a letter of explanation about Tim's depression from myself, arranged to lighten Tim's workload and it was agreed he would pass year 11 based on course work from earlier in the year. Though Tim knew he would need to do some revision in the holidays in preparation for year 12. This relieved his fear of having to repeat a year, something he felt would be humiliating.

From a psychodynamic perspective Tim had won the "Oedipal conflict" with his father. This is not a healthy state for an adolescent lad. Tim had become overly dependent on his mother through his childhood and to a great extent she had become overly dependent on him. Between age 10 and 13, whilst his father was functioning better, Tim was starting to identify with his father and individuate from his mother. However all this dissipated after his parents' divorce. He regressed into an ambivalent hostile dependent relationship with his mother. He felt rejected by his father, whose deterioration in drinking and personality robbed him of a positive role model, led to feelings of shame and a lack of confidence in his own future. His ambivalence towards his mother was perhaps replicated in his ambivalent feelings towards the girl he was attracted to, but who he felt ashamed of due to the bullying. His feelings of rejection by his father were perhaps replicated in the rejection by his best friend Max.

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Family therapy would certainly have helped him in this situation, but given the level of acrimony between the parents was not possible at this time. However dyadic work with Tim and his father by his psychologist led to significant repair in his relationship with his dad who reduced his drinking and reengaged in some positive activities such as taking Tim to see the Ashes cricket. Later on dyadic work could be done between Tim and his mother. Tim wasn't sure why, but somehow his mother had seemed less annoying once he had reconciled to some degree with his father.

A male teacher who Tim trusted (Tim didn't like the school counsellor who early on had, he felt, breached confidentiality by telling Tim's mum of her concerns) agreed to have a session at school with Tim and Max to sort out their differences. Max was a powerful player in cliques at school and high on the pecking order. Tim felt more comfortable once again being part of the group with a rise in status and respect amongst his peers restored. However he also felt strengthened to counsel Max to tone down his teasing and sarcasm towards some of the other students, for whom Tim had empathy.

Tim's GP had asked whether he should be started on fluoxetine. I informed his GP and also discussed with Tim and his mother how the academic literature, when results previously hidden by drug companies had come to light, showed that SSRIs tended to probably only work in adults and some older adolescents with more severe forms of depression, although many people had a beneficial placebo effect. However SSRIs sometimes help people with severe anxiety, and if his problems persist may eventually be worth a try given his anxiety symptoms.

On the other hand, there was a family history of lithium responsive bipolar disorder in his paternal uncle and although contentious there is a possibility of SSRIs inducing mania in predisposed individuals, so that was another risk worth avoiding. Also some people seem to have withdrawal reactions and difficulty getting off SSRIs and perhaps about 1 in 50 can get a serious suicidal/agitation/aggression reaction - so leaving fluoxetine as a last resort made sense. This discussion became part of the general discussion about "natural antidepressants" of lifestyle factors, relaxation, behavioural activation, socialisation, reconciliation and talking about his stress.

I did however discuss Temazepam, and ask his GP to prescribe it for PRN usage up to three nights per week, with most of the pills held by his mother. Tim found this a helpful adjunct some nights to relaxation, just knowing he could get a drug induced sleep roughly every second night was a bit of a relief.

I was happy to refer to him back to his psychologist, GP and the helpful male teacher at his school, noting that I would be happy to review him should his progress falter.

Written by Dr Peter Parry, psychiatrist

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