DEPRESSIVE DISORDERS IN ADOLESCENCE

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Abstract: Depression is a major public health problem affecting in a greater or lesser extent, all people, at least once in life. It ranks second on the list of the most common medical conditions, being exceeded only by hypertension. This moral and mental pain is particularly intense, associating generally with anxiety. Feeling depressed patients living with helplessness, hopelessness, desperate fatality, ridden and often tends to self depreciate himself and also may occur thoughts of suicide that can be completed. The author presents the research carried out on a group of 60 teenagers to highlight depressive symptoms at this age.

Keywords: adolescence, depression, suicidal risk, prevention

Theoretic framework

The affective disorders were among the first set of mental illness throughout the history of psychopathology. Homer, Plutarch and Hippocrates made the first references to cases of depression and melancholy, the latter putting at their basis the four humors: melancholy came from the excess of black bile.

The most important step was made by Kraepelin (1882) describing mood disorders: mania, melancholia, recurrent depression, mood medium swings. In Kraepelin's conception these diseases have several defining characteristics: clinical are expressed by the affective

disorder in the center of symptoms, and in the patients family history there are mental illness and especially emotional ones. The name given by Kraepelin and the diagnostic criteria persisted until the emergence of modern diagnostic criteria, ICD-10 and DSM (Fodoreanu, 2004).

Depression is a widespread phenomenon across the planet and that why many scientists were and are concerned about its study. In the psychiatric literature depression is defined as a "mental illness characterized by a profound change of the thymic status, of the disposition, in the sense of sadness, moral suffering and psychomotor slowing" (Micluţia, 2002, p. 101).

The concept of depression is found in a variety of areas such as psychiatry, pharmacology, neurophysiology, pathophysiology, psychoanalysis, cognitive-behavioral theory. We will address the views of psychoanalysts and cognitive-behavioral on mood disorder.

For psychoanalysts depression can be compared with the labor of mourning which is not achieved, the Ego identifies with the "lost object", taking into account his ambivalent feelings (the love and especially the hatred) towards the object. Freud in "Mourning and melancholia (1917) says that "the shadow of the object falls thus on I, which can then be tried by a special court that an object dropped. Thus, loss of the object turns into a loss of Ego and the conflict between the Ego and the loved person turns into a split between the Ego critic and the Ego amended by identification". Thus depressive must face an imaginary loss and addresses his aggression and reproaches to himself insteed of the naturally reproches for the lost object. Stressing the importance of losses in depression, Freud believes that some depression are of psychogenic origin, others are biologically determined. Psychogenic depressions

respond to psychotherapy treatments, while the endogenous to drug therapy (Freud, 2010).

The cognitivists G.A. Kelly and A.T. Beck understand depression as a disturbance of cognitive processes saying that these are inadequate and affect three areas: the Ego, the outside world and the future, which in turn disrupts representations about them. The three cognitive processes correspond to particular errors: arbitrary inference (remove the plausible explanations), selective abstraction (focus on a detail taken from the context), abusive generalizations, over- or underestimation and inadequate names. The patient should focus the misconceptions, the distortions and the maladaptive assumptions in order to correct the inadequate vision of events and Ego (Kasper, Resinger, 2003).

Each of these approaches contribute to the efficiency of depressive patient treatment and it should be chosen according to the method conductive to healing. In the past it was thought that depression is in "mind" and that a person with depression is able to heal itself. Today we know that depression is a medical condition that requires treatment and it is not a flaw or weakness (Gavrlă-Ardeelean, Gavrilă-Ardelean, 2010).

The term "depression" is subject of contrasts. It has become so common, that it is no longer taken seriously. However, it describes a real condition that we must not underestimate. In the worst case lead to suicide after states of anxiety.

In psychopathology, the disturbances of affective states were assessed according to polarity, intensity, strength, lability, content and motivational appropriateness (Ionescu, 2006).

The prevalence of depression in the general population is 5%. In the United States the prevalence of major depression is 2.6% -5.5% for

men and 6% for women. Many studies have found that unipolar depression is, in general, twice as common in women. Lifetime prevalence (= frequency of cases of disease in a community) of the major depressive disorder (disease the most common) is 15% (maybe 25% in women).

Differences are noted by gender and age. The prevalence of major depressive disorder is more common in women (explanations could be the hormonal differences, the differences between the stress factors for the two sexes, the effects of birth) (Fodoreanu, 2004, p.196).

The clinical manifestations of depression can be summarized after Kielholtz by the triad: sad mood or anxiety, inhibition of thinking and centrifugal mental disorders and psychomotor functions (Galbard, 2007).

The clinical picture is represented by the cardinal psychopathological manifestations and accessories manifestations. The cardinal psychopathological manifestations consist of depressed mood, thought inhibition and inhibition of the centrifugal functions.

Depressed mood is manifested as: sadness, tension, anxiety, inner restlessness, dysphoria (sullen indifference), the impression that you can not have feelings, vital sadness with body location (Gelder, Gath, Mayou, 1994).

Inhibition of thought is expressed by: limited and poor associations, slow thinking and tiring, thinking in vicious circle, obsessions, monoideism, interior vacuum, suicide ideation (Lăzărescu, Bărănescu, 2011).

Centrifugal functions inhibition is found as: inhibition of the will, the inability to make a decision, ambitendences, difficult start, depressive stupor, psychomotor inhibition, bent posture, bradikinesia, soft and monotonous voice (Montreuil, Doron, 2009).

In other clinical picture is present the agitation as motor restlessness, crying, lamentation, the feeling of being overwhelmed hopeless, tedious, harassed. Delirant manifestations and the somatic symptoms are interpreted by the Swiss school as accessories symptoms (Robinson, 2010).

In many depression, especially in the melancholic type, we meet what Kurt Schneider described as vital sadness. It is a devitalization of the existence accompanied by limitation and inhibition of vital feelings, emotional background of existence, of all emotional experiences, being profoundly altered. The disorder of the vital feelings outwardly by tension, weight and pain are felt, especially in the field of heart, respiratory and gastric and less cephalic sphera (Tudose Tudose, Dobranici, 2011).

For Staehelin, the vital sadness is a kind of defeat of the "vital moose" manifested by the inhibition of the primary instinctual impulses, of the start-up energy, of the resistance reaction, followed by an awkward feeling and a heavy and unpleasant mood. Many authors agree that the vital sadness is a feature of melancoliforme endogenous depression. In many types of depression (reactions, fatigue, involution), the sadness can secondary devitalize but the clinical manifestations are the same. The presence of the vital sadness early in the disease advocates an endogenous depression (Birt, 2001).

On the inelectual plan the inhibition is felt as bradipsychia and impoverishment of the ideational content. Memories are evoked with difficulty. The fforts of concentration and reflection are impossible. The patient focuses heavily on a conversation or reading, his speech being fragmented up to mutism. Although the orientation and perceptions are correct, the patient being overwhelmed by his mental pain not give any

attention to the outside world at all and did not retain anything but only the elements that feed his depressive rumination (Enăchescu, 2008).

Frequently, the depressed consciousness is besieged by ideas of autolysis (suicide), the death is desired as an atonement, an obligation, a penalty, as the only possible solution to evade from the unbearable moral torture. Refusing food is a way to express refusal to live. Suicidal behaviors are frequent and severe onset and may occur during the early period, in the period of chemotherapy or in the recovering period (Cosman, 2010).

The depressive supports painfully his vital fatigue, being unable to conceive, decide and react. The requests seeking to distract him from his morbid concerns or to stimulate him, merely amplify the feelings of incapacity and personal impairment.

The affectivity inhibition is expressed by anesthesia, the patient being unable to be more exciting, having no feelings for the persons close to him.

Indecision and feeling of helplessness, expression of the inhibition of the will, which exists since the beginning of a melancholic episode becomes worse up to complete aboulia. The entire activity is slowed. Ordinary acts require a huge effort, body cares are neglected.

Sleep disorders are present mostly in the form of insomnia and rarely as drowsiness. Clinicians felt that morning insomnia are characteristic of endogenous depression, while sleep insomnia advocating a psychogenic depression. From the predominance of psychopathological symptoms, clinicians described as clinical forms: simple depression, anxiety, stuporous and delirante depressions.

In the simple form the patient is inactive, asthenic, the moral pain is low, often absent, the patient charging a ridiculous helplessness and intellectual sterility (Micluţia, 2002).

As clinical forms the authors recorded also the mixed forms and monosymptomatic ones.

After the symptoms intensity the depressive disorders can present as severe depressive episode, moderate and easy one.

Major depressive episode is overlapping the unipolar depression in the sense of many authors.

Major Depressive Disorder in American psychiatrists concept (DSM IV) is characterized by one or more major depressive episodes (at least 2 weeks of depressed mood or loss of interest) accompanied by at least four additional symptoms of depression (DSM IV, 2003).

To count as major depressive episode a symptoms must be present soon, or be clearly worsened compared with the pre-episodic condition of the patient. The symptoms must persist for most of the day, nearly every day for at least 2 consecutive weeks. The episode must be accompanied by sadness or clinically significant impairment in social, occupational or other important areas of functioning. In patients with mild episodes, functioning may be normal but requires an effort considerable increased (Galbard, 2007).

Loss of interest or pleasure is nearly always present and is associated with social withdrawal and neglect of the hobbies.

On the clinical level are frequent sadness, irritability, tendency to introspection, obsessive rumination, anxiety, phobias, and excessive concerns relating to health. Sometimes panic attacks may be present. In interpersonal relations may occur problems of marital couple, professional, school, drug or alcohol abuse, excessive attendance of

medical services. Attempted suicide or achieved suicide are common, the risk is increased in people with psychotic paintings with previous suicide attempts in the personal history and hereditary hystory etc. It can also be recorded a high rate of premature deaths by general medical condition (Gelder, Mayou, 1994).

The major depressive episodes may be preceded by psychosocial events with high load (death of a beloved one, divorce, etc.). The symptoms of a major depressive episode is influenced by sex, ethnic and cultural factors.

Prodromal period manifested with symptoms of anxiety and depression can last for weeks or months. The duration of a major depressive episode is also variable. An untreated episode last usually 6 months or more.

The research

The chosen research area was that of clinical psychology, with particular reference to the study of depression in adolescence. This research aims to show how depression among adolescents is presented, focusing on sex (male and female).

In our research we started from the following hypothesis:

H: We assume that depression is more common and has higher degrees in the girls than in the boys adolescents.

For this research we chose a group of subjects consisting of 60 adolescents, 30 boys and 30 girls, aged between 15 and 25 years. In the three age groups considered: 15-18 years, 19-22 years and 23-25 years are assigned an equal number of subjects, including: the first age group have 19 subjects, the second age group have 21 subjects, and the third group have 20 subjects.

To collect data on depression, we applied a single questionnaire: Beck's Depression Inventory - BDI.

Suitable for all ages, BDI, is the best known inventory for measuring depression levels and has been translated and used successfully in many socio-cultural spaces. It is easy to administer, requires a short time, can be applied to different segments of the population, regardless of culture or age, thanks to a friendly language. Beck Depression Inventory (BDI) from 1988 is the most frequently quoted and most widely used measure of depression based on selfdescription. Moreover, it has become a benchmark for validate other instruments or scales of selfevaluation.

Verification of the hypothesis:

- *There are gender differences in the frequency and the intensity of the depression in adolescents*.

Table 1 and Figure 1 shows the results obtained by the BDI for the whole lot of teenagers.

Table 1.

The frequency of depression in the studied group

Depression presence	Number
depressed	35
non- depressed	25

The table and the figure illustrate that data obtained by us not match the literature concerning the prevalence of depression in the general population (which varies between 2% and 25%). In this case, as a percentage, the frequency of depression should be more than 50%. We interpret this as being influenced by two factors: on the one hand the studied sample size (our sample is small compared to the general population and can not provide estimates for this) and secondly, due to

age segment chosen to do the sample (adolencence - age period in which depression are very common and might even say that it is a feature of this age, due to many changes that occur in adolescence and numerous social and professional requirements with which must cope the adolescents).

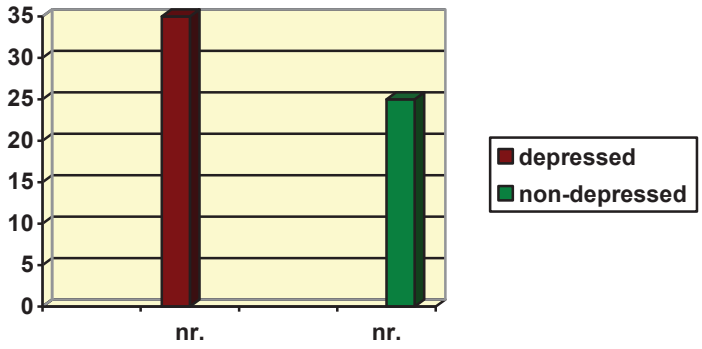

Figure 1. The frequency of depression in the studied group

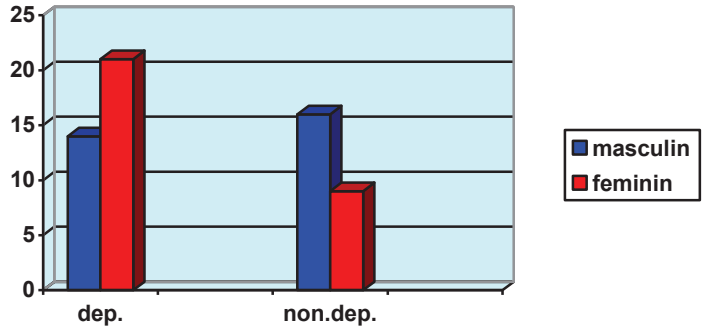

Figure 2. Distribution of cases of depression by gender

Looking at the table and figure above, we can say that if the gender distribution of depression, our results are consistent with the literature. The number of cases of depression among female subjects is

almost double the number of subjects with depression among male subjects.

Although adolescence is in itself a very vulnerable period, it seems that girls are more prone to depression than boys. We interpret this aspect, on the one side, by the fact that the hormonal changes that occur in the body of the girls are more numerous and more important than for boys. On the other hand stressors acting on girls are different from those acting on boys - one example is the stress induced by the ideal of feminine beauty as required by the society and which is one of the main concerns of girls at this age, appearance that boys are not experiencing.

Thus, the results of the research on gender differences in depression are congruent with most international studies on this issue, showing predominantly female subjects.

The differences between the frequencies of the two groups (boys and girls) are statistically significant at a significance threshold of $p < .01$.

These data support that the first part of our hypothesis was confirmed: *depression is more common among girls than among boys during adolescence, in a proportion of about 2 for 1.*

The second part of the hypothesis concerned the fact that there are gender differences in the intensity of depression.

For a more detailed analysis of gender differences on depression, we compared female subjects and male subjects according to three levels of intensity of depression (according to Beck Depression Inventory): mild depression, moderate depression, severe depression.

Of the total number of female subjects ($n = 30$) included in the survey, 21 reported depressive symptoms, of which - two severe depression, 6 - moderate depression and 13 - mild depression (Table 2 and Figure 3).

Table 2

Frequency of depression forms for the sample of girls (N = 30)

Depression Types	Fr. Abs.	Fr. Cum.	Fr. Abs(↑)	Fr. Abs(↓)	v	v^2
A	13	30	0,44	1,00	27	729
B	6	17	0,2	0,57	24	576
C	2	11	0,06	0,37	28	784
D	9	9	0,30	0,30	21	441
Total	∑=30		∑=1		∑=100	∑=2530

where: A - mild depression; B - moderate depression;
C – severe depression D – non-depressed

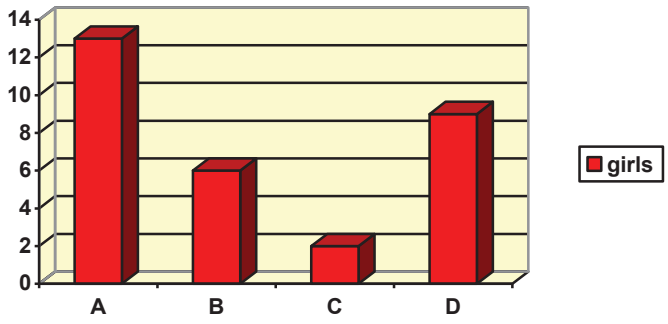

Figure 3. Frequency of the forms of depression for the sample of girls (N = 30)

It can be seen that the highest number of subjects which recorded significant scores for depression is the female subjects with mild depression. We could say that this type of mild depression usually accompanies adolescence female subjects being due to various internal and external fatori facing subjects. The internal factors include: hormonal changes, body changes that occur during this period, acceptance and habituation with her own body image, building a new self-image etc. The external factors include: the strained relations with the parents, the growing professionally requirements (school has great demands from

students arrived at this age) large volume of material to be learned, adapting to new roles and social responsibilities etc.

A total of 6 subjects had scores that classified them as moderate depression. For them the tiredness is almost constant and the depressed mood and the feeling that they are not loved are present almost daily. The subjects in this category were reported also sleep disorders, consisting in sleep insomnia, mainly due to ruminative thoughts that they will not meet the demands of school and social, that they will not be at their parents' expectations.

A total of 2 cases were categorized as severe depression. For these cases, the BDI scores should be a warning and an incentive to consult a specialist in the area (whether it is a psychiatrist or a clinical psychologist). The accentuated depressed mood became permanent and they will not be able to extricate themselves from this situation without professional help.

From the sample of boys, 11 cases had scores that include them in the category of mild depression. Boys do not have the same stressors as the girls, but they face a number of bodily changes, and they have to accept the new self-image and adjust it in accordance with the requirements of social and personal ideals. In addition, at this age for boys comes also the fight for supremacy, in the school group or the environment, as the necessity to join a group of elderly people who provide them with appreciation and recognition. Difficulties in relationships with parents grow, because at this age boys are considered biologically independent, but still dependent of their family financially and emotionally. These discrepancies may contribute to a feeling that they are not understood and not appreciated at their true value.

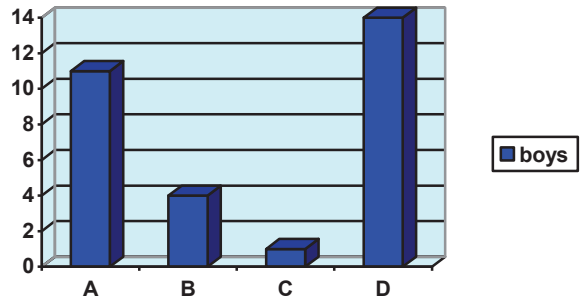

Figure 4. The frequency of the forms of depression for the sample of boys (N = 30)

where: A - mild depression; B - moderate depression;
C – severe depression D – non-depressed

A total of four cases obtained scores equivalent to mild depression. For these cases over the problems inherent in this period overlapped acute family problems (divorce of parents in two cases, parents going abroad for work in two other cases). This has fueled the already existing depressive manifestations and led to accentuate them.

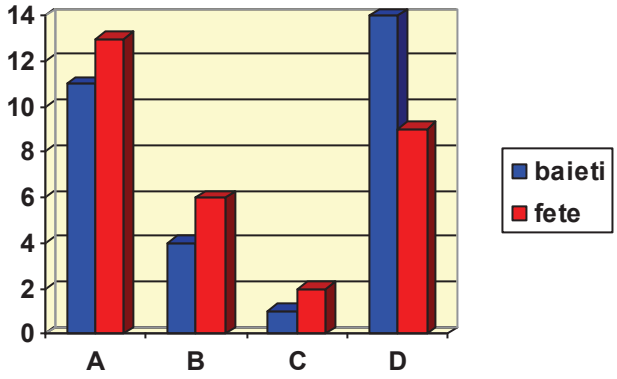

Figure 5. The compared frequencies to boys and girls on the intensity of depression

where: A - mild depression; B - moderate depression;
C – severe depression D – non-depressed

A single case of group of boys shows scores to amount to severe depression. In a way this aspect is justified (the father died in a car accident), but goes beyond a prolonged duration of mourning and the depression requires professional help.

It is noticeable that girls record higher levels in all the three forms of depression: for mild depression compared with 11 boys and 13 girls; moderate depression compared with 4 boys and 6 girls; and severe depression compared to a boy and two girls. Number of non-depressed subjects is lower among girls than among boys.

These data allow us to state that in terms of intensity of the depressive states there are significant differences by gender. Differences between boys and girls for the three types of depression are statistically significant at a significance level of $p < .01$. Thus *the second part of our working hypothesis has been validated in the practical.research.*

The hypothesis that we assumed at the begining of the research that there are gender differences in the frequency and intensity of the depression among adolescents is fully confirmed by the practical research done.

Conclusions

Depression is the most common of the psycho-emotional disorders of the modern world. It is characterized by very diminished mental tone, accompanied by lower self-esteem and lack of any kind of pleasure or interest in things around. The impact of the depression on individual lives is major: about 4% of patients come to commit desperate acts and suicide attempts.

Also, 60% of all suicides occur against a background of major depression or other mental disorder from this category. Depression

interferes with thinking and actions on short and long term of the patient and in the severe cases it greatly affects the quality of life, interfering with daily activities, work or relationships with loved ones.

Experts consider depression a chronic condition that requires long-term treatment, as with other chronic diseases that have an organic component. Despite the fact that most people face at some point in life with an episode of depression, there are many cases recurrent or persistent that are a real therapeutic challenge for physicians or psychologists.

By establishing an effective treatment we can relieve symptoms and the patient life returns to normal even after few weeks after the start of therapy.

Currently there are several treatment options for treating the depression and the disorders with depressive component such as bipolar disorder. Medications administered to patients enter in the class of antidepressants and include monoamine oxidase inhibitors, tricyclic antidepressants, tetracyclic, selective serotonin reuptake inhibitors.

Psychotherapists and psychologists began to take seriously the risk of depression in children. Research shows that often the depression that occurs in children persists and becomes recurrent during adulthood, especially if untreated. The presence of depression in children is predictive of severe depression in adults.

Depression in adolescence comes at a time of great personal transformation - teen develop their distinctive identity not indentic with that of his parents. Depression in adolescence often coexists with other disorders such as anxiety, eating disorders or substance abuse.

Depression can be approached through various psychotherapeutic methods. Mainly depression can be treated by short-term therapies, such

as cognitive therapy, interpersonal therapy, behavioral therapy. Depending on the profile of the person with depression and the type of depression can be advised also psychoanalytic guidance therapy, family therapy and other types.

The effectiveness of psychotherapy in depression is widely recognized. Psychotherapy contributes to improve the quality of life and to reduce the total cost of treatment by decreasing the number of episodes. Psychotherapy as the only method of treatment is an important strategy applied to a relatively small group of patients with mild and moderate depression. It is an essential approach for patients who can not take drugs.

Combining psychotherapy with antidepressant medication has been shown to have superior results of each approach separately. Psychotherapy augments the effect of antidepressant medication and is a factor that increases compliance. Psychotherapy is not only effective in depression, but can reduce costs by improving the disability associated with depression.

The cognitive-behavioral therapy has been the most studied and found to be most effective in depression. It is a structured method and generally consists of 12-16 sessions.

The management of depression and depressive problems in adolescence is part of a paradox, which explains the difficulty, specificity and importance of treatment.

In fact, the first aim of care is to achieve a reduction or disappearance of symptoms:

- the most debilitating: slowness, withdrawal, lack of interest, irritability blocking the major social relationships etc.

- the most painful: the moral suffering, the devaluation, the idea of guilt etc.

- the most threatening: suicidal ideas or plans.

The overarching goal of the therapist must be to reinvigorate, revitalize and re-launch the mental process of this age. This mentally labor confronts the ill teenager with sadness, bad mood, depressed mood or even depression, with everything that characterizes this feature of puberty dysphoria in which the ability to distinguish, the frustration tolerance, the acceptable losses are elements that are part of the psycho-dynamic stakes: many teens, if not all, have at some point experienced a depression.

Treatment of depression in adolescence would not be limited to symptoms sedation (important, of course), but also be concerned with the recognition and promotion of the maturation process specific to this age, process which incorporates a component with depressive disorders.

Bad mood, sadness, have a positive and favorable potential, as these conditions allow to the adolescent Self, temporarily depressed, to engage in a process of disinvestment-renunciation and to overcome the fear of a depressive collapse. If subsequently, there will be new period of depression, the teenager will know how to overcome them, due to its old experiences.

Psychotherapy can be done in groups or individually by psychologists, psychotherapists and psychiatrists, counselors. In more complex forms of depression is used a combination of medication and psychotherapy. Cognitive behavioral therapy is the most studied form of treatment for depression in children and adolescents. Successful psychotherapy reduce the recurrence of depression even after it was over and replaced by occasional meetings.

The most studied form of psychotherapy for depression learn patients how to defend themselves, new ways of positive thinking and the modification of counterproductive behaviors. Combining medication with psychotherapy seems to give good results. Some variables predict success for cognitive behavioral therapy in adolescents: high level of rational thinking, less melancholy, fewer negative thoughts. It is especially beneficial in preventing relapse.

In conclusion, depression in adolescents is common, severe and result in intermediate and long-term morbidity and in mortality. For clinicians who work with young people and their families is important to know the issues reported so that high-risk adolescents can be detected, evaluated and treated using appropriate therapy. It will put more and more emphasis on prevention strategies for high-risk groups.

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