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Depression and Suicidality in the Adolescents in Osijek, Croatia

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A B S T R A C T

Mood disorders in children and adolescents and their treatments have received increasing attention and clinical investigation over the last few decades. The core features of mood disorders are essentially the same across the life span. Developmental level, however, appears to influence the expression of certain mood symptoms with greater frequency than other within the framework of depressive disorders. Suicide is the fourth leading cause of death in children between the ages of 10 and 15 years and the third leading cause of death among the adolescents and young adults 15–25 years. In this article the authors presents cross-sectional study done on the sample of 286 adolescents. Adolescents fulfilled self-rating scale Beck Depression Inventory for the screening of the depression and suicidality. In our sample 3.85% of the adolescents fulfilled the criteria for severe depressive episode and the 5.94% of the adolescents fulfilled criteria for moderate depressive episode. Also on the item of suicidality (Item 9) 0.7 % of the adolescents had very high score, while 8.4 had significant score for the suicidal risk. Our results are in concordance with similar epidemiological studies done world while.

***Key words**: depression, suicidality, adolescents*

Introduction

Mood disorders in children and adolescents and their treatments have received increasing attention and clinical investigation over the last few decades. The core features of mood disorders are essentially the same across the life span. Developmental level, however, appears to influence the expression of certain mood symptoms with greater frequency than other within the framework of depressive disorders.[1]

Reports of suicide by children and adolescents have increased over the last decade. Suicide is the fourth leading cause of death in children between the ages of 10 and 15 years and the third leading cause of death among the adolescents and young adults 15–25 years.[2]

Recent findings indicate that psychiatric disorders have relatively less association with suicidal behavior among children and younger adolescents and that family conflict and peer difficulties may be more significant in the expression of suicidal behavior in this age group.[3–7]

Aim of this cross-sectional study was to define in what percentage does depression appears in the adolescents in our community, as well to assess suicidal risk in those depressed adolescents.

Materials and Methods

Adolescents in the age from 14–18 years were rated with self-report instrument for depression, Beck Depression Inventory. Beck depression inventory was developed in the early 1960s to rate depression severity, with the focus on behavioral and cognitive dimensions of depression. The current version the Beck depression inventory-II, has added more coverage of somatic symptoms to be compatible with DSM-IV and covers the most recent 2 weeks. The BDI includes 21-self items, each of which has four statements describing increasing levels of severity; the total score range from 0 to 4. Scores of 0–13 are considered minimal, 14–19 mild, 20–29 moderate, 30–63 severe. The scale can be completed in 5 to 10 minutes. It is a self-report instrument, used to screen for major depression.[8] The study was conducted in the Medical High

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School in Osijek, Croatia and in the Professional Handicraft High School in Osijek, Croatia. It was conducted as an epidemiological cross sectional school survey.

286 adolescents fulfilled the Beck depression inventory as well as the questionnaire about sociodemografic background. 99 of them were male sex and 187 were female sex. Most of them (142) had very good school performance, 38 of them had highest grades, while 13 attended the same class again. 182 of the adolescents had mothers with finished high school, similarly 187 fathers finished high school. Both parents were employed in 96 adolescents, only father was employed in 89 of the adolescents, only mother in 51, and 8 of them had both parents without job. 6 of the adolescents had retired father and 1 retired mother. We also asked adolescents about health status of their parents. 86 of them had healthy mother and 84 healthy father. From chronic somatic diseases suffered 11 mothers and 10 fathers, while from psychiatric diseases suffered one mother and three fathers. Three mothers and three fathers had both somatic and psychiatric diseases.

Results

Beck Depression Inventory Scores were divided in 4 groups according to the prescribed guidelines. In the group with the lowest score (0–13) were placed most of the population, 82.17%, which tells us about the adolescent population without symptoms of depressive disorder. 8.04% of the adolescents had fulfilled criteria for mild depressive episode (scores from 14–19), while 5.94 % fulfilled criteria for moderate depressive episode (scores 20–29), and 3.85% fulfilled criteria for severe depressive episode (scores 30–63). (Table 1)

In our study we paid special attention to the Item 9 of the Beck Depression Inventory which represents suicidal risk. Item has score range from 0 to 3. Answers no.2 'I wish I was gone', and no.3 'I would kill myself if I had a chance' represents significant suicidal risk. In our adolescent sample 8.4% answered 'I wish I was gone', and 0.7 % answered 'I would kill myself if I had a chance'. As we can see 9.1% of the adolescent sample has serious suicidal risk. (Table 2)

Discussion

The epidemiology of mood disorders and suicide among children and adolescents is complicated by their increasing rates with increasing age. Also, over the last few decades, the criteria for diagnosing the disorders have changed. Finally, the reported incidence of mood disorders among youths over the last few decades has consistently increased, and the age of onset has decreased. This phenomenon has been called the 'cohort effect'. It is most evident in studies of mild to moderate depression.[1]

TABLE 1
RESULTS OF THE BECK DEPRESSION INVENTORY

Score	N	%
0–13	235	82.17
14–19	23	8.04
20–29	17	5.94
30–63	11	3.85

TABLE 2
RESULTS ON THE ITEM SUICIDALITY (Item 9) FROM THE BECK DEPRESSION INVENTORY

Score	N	%
0	226	79.00
1	34	11.90
2	24	8.40
3	2	0.70

The lifetime prevalence rate of major depressive disorder in adolescents is estimated to fall between the 15 and 20 percent, similar to that in adult population. Epidemiological studies of mood disorders in children and adolescents support the notion that pure depression is rare among youths. Among adolescents, about 5 percent in the community have major depressive disorder. [1,9–11] We can see from our results that 3.85% of the adolescents fulfilled criteria for severe depressive episode, and the 5.94% of the adolescents fulfilled the criteria for moderate depressive episode. Young, depressed children commonly show symptoms that appear less often as they grow older, including mood-congruent auditory hallucinations, somatic complaints, withdrawn, sad appearance, and poor self-esteem. Symptoms that are more common among depressed youngsters in late adolescence than in young childhood are pervasive anhedonia, severe psychomotor retardation, delusions, and a sense of hopelessness. Symptoms that appear with the same frequency regardless of age and developmental status include suicidal ideation, depressed or irritable mood, insomnia and reduced ability to concentrate[1,12–15].

As we can see from the literature suicidal ideation appears in all ages in depressed patients, but, reports of suicide by children and adolescents have increased over the last decade. Suicide is the fourth leading cause of death in children between the ages of 10 and 15 years and the third leading cause of death among the adolescents and young adults 15–25 years.[2]

In our adolescent sample 8.4% answered 'I wish I was gone', and 0.7 % answered 'I would kill myself if I had a chance'. As we can see 9.1% of the adolescent sample has serious suicidal risk. Children's mood are especially vulnerable to the influences of severe social stressors, such as chronic family discord, abuse and neglect, and academic failure. Most young children with major depressive disorder have histories of abuse or neglect. Children with depressive disorders in the midst of the toxic environments may have remission of some or many depressive symptoms when the stressors diminish or when the children are removed from the stressful environment[2,6,7,16–18].

Conclusion

Given the high prevalence of depressive disorders and the significant burden of disease they represent within our community, early intervention in depressive disorders is critical research agenda for the future. The task ahead is to identify both psychosocial and the psychiatric risk factors to develop prevention strategies for suicidal behavior among adolescents.

REFERENCES

1. KAPLAN HI, SADOCK BJ, Comprehensive textbook of psychiatry (Lippincott, Williams and Wilkins, USA, 2000). — 2. NRUGHAM L, LARSSON B, SUND AM, J Affect Disord, 12 (2007) 18. — 3. FROJD SA, NISSINEN ES, PELKONEN MU, MARTTUNEN MJ, KOIVISTO AM, KALTIALA-HEINO R, J Adolesc, 10 (2007) 17. — 4. KIM J, RAPEE RM, JA OH K, MOON HS, J Adolesc, 12 (2007) 10. — 5.BEEVERS CG, ROHDE P, STICE E, NOLEN – HOEKSEMA S, J Consult Clin Psychol, 75 (2007) 888. — 6. MANONGONDO JA, RAMIREZ GARCIA JI, J Clin Child Adolesc Psychol, 36 (2007) 593. — 7. HARKNESS KL, LUMLEY MN, TRUSS AE, J Abnorm Child Psychol, 12 (2007) 19. — 8. BESIER T, GOLDBECK L, KELLER F, Psychother Psychosom Med Psychol, 10 (2007) 9. — 9. ALLEN NB, HETRICK SE, SIMMONS JG, HICKIE IB, Med J Aust, 187 (2007) 15. — 10.CARR A,Dev Neurorehabil, 10 (2007) 1. — 11. HEINRICHS N, HAHLWEG K, Dtsch Med Wochenschr, 132 (2007) 2208. — 12. LEUSSIS MP, ANDERSEN SL, Synapse, 62 (2008) 22. — 13. DUBICKA B, WILKINSON P, Evid Based Ment Health, 10 (2007) 100. — 14. ZUCKERBROT RA, CHEUNG AH, JENSEN PS, STEIN RE, LARAQUE D, Pediatrics, 120 (2007) 1299. — 15. CHEUNG AH, ZUCKERBROT RA, JENSEN PS, GHALIB K, LARAQUE D, STEIN RE, Pediatrics, 120 (2007) 1313. — 16. LANDMAN-PEETERS KM, ORMEL J, VAN SONDEREN EL, DEN BOER JA, MINDERA RB, HARTMAN CA, Depress Anxiety, 10 (2007) 16. — 17. DESHA LN, ZIVIANI JM, NICOLSON JM, MARTIN G, DARNELL RE, J Sport Excerc Psychol, 29 (2007) 534. — 18. DADKAH A, RAOUFI MB, Percept Mot Skills, 105 (2007) 531.

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DEPRESIJA I SUICIDALNOST U ADOLESCENATA U OSIJEKU, HRVATSKA

SAŽETAK

Poremećaji raspoloženja u djece i adolescenata kao i njihovo liječenje su unatrag nekoliko desetljeća pod pojačanom pažnjom istraživača. Glavni simptomi poremećaja raspoloženja su isti tijekom cijelog života. No, stupanj razvoja utječe na veću pojavnost određenih, specifičnih simptoma u sklopu depresivnog poremećaja. Suicid je na četvrtom mjestu uzroka smrti djece u dobi od 10–15 godina, dok je na trećem mjestu u adolescenata u dobi od 15–25 godina. Našim epidemiološkim istraživanjem, pregledom trenutnog stanja u uzorku od 286 adolescenata koji su popunjavali samoprocjensku skalu Beck Depression Inventory, dobili smo podatke da je 3,85% adolescenata ispunjavalo kriterije za tešku depresivnu epizodu, a 5,94 % je ispunjavalo kriterije za umjerenu depresivnu epizodu. Također smo analizirali Item 9 koji ukazuje na suicidalni rizik i dobili podatak da je 0,7% adolescenata s vrlo visokim suicidalnim rizikom, a 8,4% sa visokim suicidalnim rizikom. Rezultati našeg istraživanja su u skladu sa drugim studijama rađenim u svijetu.