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Identifying and treating adolescent mental health problems in primary health care

Identificiranje i liječenje mentalnih problema adolescenata u primarnoj zdravstvenoj zaštiti

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Summary

The period from late adolescence to the mid twenties, known as transition to grown up age, is a risk period for development depression. Stomach pain, headache and fatigue are common symptoms in children and adolescents suffering from depression. Patients often fail to mention their emotional problems during the family physician's consultation. Together with the physician's insufficient ability to recognize the hidden part in the physician-patient relationship, it makes early diagnosis and adequate intervention more difficult.

Aim: To enlighten the role of a well-educated family physician as a coordinator in team work and shared medical care in identifying and treating adolescent mental health problems.

Method: Family physician's bio-psychosocial approach.

Results: Case report of an adolescent girl who developed depression connected to multiple family environment problems is presented. Problems connected to depression started five years ago. They appeared as somatic troubles, stomach pain and headache. The girl had a whole range of predisposing risk factors for depression, including the mother's mental illness, deteriorated family relationships, multiple family violence, low support and cooperation with other family members.

Conclusion: The role of a well-educated family physician as a coordinator in team work and shared medical care is crucial in identifying and treating adolescent mental health problems.

Key words: family medicine, comprehensive health care, adolescent, depression

Sažetak

Razdoblje od kasne adolescencije do sredine dvadesetih godina, poznato je kao prijelazno prema odrasloj dobi, a ujedno i rizično razdoblje za razvoj depresije. Uobičajeni simptomi djece i adolescenata koji boluju od depresije su bolovi u trbuhu, glavobolja i umor. Tijekom posjete obiteljskom liječniku, bolesnici često zaboravljaju napomenuti svoje emocionalne probleme što zajedno s liječnikovom nedovoljnom sposobnošću da prepozna skriveni dio u odnosu liječnik-bolesnik, otežava rano postavljanje dijagnoze i otežava intervenciju.

Cilj. Rasvijetliti ulogu dobro educiranog obiteljskoga liječnika, kao koordinatora u timskom radu i podijeljenoj zdravstvenoj skrbi u identificiranju i liječenju mentalnih bolesti adolescenata.

Metoda. Biopsihosocijalni pristup obiteljskoga liječnika.

Rezultati. Prikaz slučaja adolescentne djevojke s mnogobrojnim obiteljskim problemima, koja je oboljela od depresije. Simptomi depresije započeli su prije pet godina manifestirajući se kao somatski poremećaji – bolovi u trbuhu i glavobolje, a kulminirali su višestrukim samoozljeđivanjima po koži u vidu ogrebotina, rana i opekotina. Djevojka je imala cijelu paletu rizičnih predisponirajućih čimbenika za razvoj depresije: majčinu mentalnu bolest, narušene obiteljske odnose, obiteljsko nasilje, malu podršku okoline i lošu

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suradnju s ostalim članovima obitelji. Obiteljski liječnik, u čijoj su skrbi bili i otac i mlađi brat, pravovremeno je uključio socijalnu službu u rješavanje problema mentalno oboljele nasilne majke, te uputio djevojku na psihijatrijsko liječenje, te provodio trajnu suportivnu psihoterapiju .

Zaključak. Uloga dobro educiranog obiteljskog liječnika, kao koordinatora u timskom radu i podijeljenoj zdravstvenoj skrbi, od presudne je važnosti u identificiranju i liječenju mentalnih bolesti adolescenata.

Ključne riječi: obiteljska medicina, sveobuhvatna zdravstvena zaštita, adolescent, depresija

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Introduction

The period from late adolescence to the mid twenties, known as transition to grown up age is characterized by high frequency of depression.[1] The clinical picture of depression is known as an illness with a thousand faces that vary, depending on age. Stomach pain, headache and fatigue are common symptoms in children and adolescents. Considering the fact that the majority of children and adolescents visit their family physician on a regular basis, the position of a family physician is ideal for early detection of mental health problems. Despite that, only a small number, one fourth to one third of all adolescents who suffer from depression, gets an adequate treatment. The main reasons for not recognizing depression are the physicians' knowledge, their attitudes and skills, as well as many other factors. Patients often fail to mention their emotional problems during family physician's consultation, which, together with the physician's insufficient ability to recognize the hidden part in the physician-patient relationship, make the early diagnosis and adequate intervention more difficult.

Literature shows that the risk of depression is related to the social, interpersonal and family context in which the child lives. They may have a great influence on the development of depression in a young person, with either low or high genetic risk. For example, intense family conflict, low socio–economic status and early death of a parent have proved to be increasing risk factors for childhood and adolescence depression.[2] Family violence is a major social and medical problem. It is happening in all countries regardless of social, economic, cultural or spiritual values. Morbidity as a consequence of family violence usually manifests as poor health status, low quality of life and frequent usage of medical services.[3] Children coming from families with violence history tend to develop psychological and behavioural problems, risking poor health condition in later stages of their lives.[4] Many health problems are related to family violence. These problems include acute trauma such as death, unwanted pregnancy, posttraumatic stress syndrome, somatisation, suicide and drug abuse.[5] Psychosomatic disorders and unspecific chronic pain are also very frequent.[6]

Recent studies show the tendency of shifting the first symptoms of depression to younger age groups. Almost one in eight adolescents and one in 33 children have experienced depression. The frequency of pre-puberty depression is equal among boys and girls, but the frequency doubles among girls after puberty.[7,8] Depressed children are short-tempered, peevish, sulky, develop behavioural problems, and lack interest in playing. At school age, a child might develop phobias, tendency to social isolation, lower school grade. They are prone to lying and theft.

Depressed adolescents often sleep a lot, have appetite problems and they are prone to aggressive behaviour and suicidal thoughts. The warning signs for depression include: running away from home, diminished interest in friends, consumption of various addictive substances, increased irritability, problems with communication and relationships, low self-esteem, annoyance, boredom, neglect of hygiene and physical appearance.[9]

Family physicians fail to recognise two out of three depressed patients in primary health care, which appoints that these patients have not received any treatment.[10] Studies show that only 50% of all depressed adolescents get depression diagnose before their adult age and 50% of these recognized as depressed get an adequate treatment.[11,22] In primary health care, young people who repeatedly visit their physician with somatic symptoms without medical findings should consider psychological problems including depression.[13]

Intentional self-harm behaviour is not rare among depressed adolescents. However, little is known about effective treatment at this age.[14]Recent studies about non-suicidal behaviour among adolescents indicate that 15 to 20% of adolescents experienced at least one non-suicidal self-inflicted injury.

In spite of medical problem importance of self harmed depressive adolescent, there are not many researches on this issue in accessible literature.

The aim of this paper was to present an interesting case of a depressed adolescent and to enlighten the role of a well-educated family physician as a coordinator in team work and shared medical care in identifying and treating adolescent mental health problems.

CASE REPORT

Reason for the visit

Patient M. F., aged 17, was a third grade secondary school student. She came to the family physician's office for antidepressant prescription complaining on fatigue and low blood pressure.

Past history

The patient had been treated for depression for four years. Problems connected to depression started five years ago. They appeared as somatic troubles, stomach pain and headache. She visited the general practitioner repeatedly because of respiratory symptoms, acne, headaches, weakness, gastrointestinal problems or vague abdominal pain. Physical examination and laboratory findings did not detect any pathological cause. When the signs of self-aggression appeared, i.e. after finding numerous visible superficial injuries like excoriation on the forearms and hands, burn scars on the hand dorsum and wounds caused by cuts at lower extremities, the patient was sent to a psychologist who, understanding the seriousness of the problem, sent her further to a psychiatrist. The psychiatrist diagnosed depression and prescribed antidepressants.

At first the patient was taking **s**ertralin 50 mg per day and later fluoxetine 20 mg per day (because of sertralin's side effects – nausea, vomiting and dizziness).

Family history

Her father and younger brother were in health care with the same physician. The brother was suffering from a hyperactivity disorder. The mother was not in care with the same physician. According to the father, their mother was mentally ill but refused treatment.

Bio-psychosocial approach of the family physician

Information on family problems was obtained by the father. Both marriage problems and disturbed mother-daughter relationship were present. The mother was mentally ill and had been refusing help for years. She abused her daughter and the whole family, physically and mentally. Since the whole family was new on the physician's list, it took almost a year for the father to seek a physician's help, after his wife had started abusing him physically. The family physician contacted social service which advised the separation of the spouses, which was soon followed by divorce. Recommended by the family physician, the father was given custody of the patient and her brother.

After the divorce, the patient's health improved. Her mother was diagnosed with schizophrenia and started treatment under social service custody.

Besides psychiatric consultations, the patient regularly visited her family physician for supportive talks. After six months, the patient's recovery became visible. She developed a fair relationship with her mother and drug therapy was reduced.

Psychotherapeutic approach

The patient had appointments with her physician at first once a week, at the end of working day. After ten seasons the appointments were changed to once in two weeks. Whenever the girl came for a prescription or referral, the physician found a few minutes for a few empathic words or to show interest in school results. Little by little, encouraged by the physician's empathic motherhood figure, the girl revealed her problems for the first time. The physician lead the conversation by returning from time to time to enlighten the hard moment, trying not to disturb the girl too much. It was revealed that the problems with her mother had started in early childhood. The mother was a housewife and the father, who worked as a computer expert for his own company, was often absent. According to her story, her mother had tortured her continuously, physically and emotionally, for as long as she could remember. She used to blame her for the bad relationship with the husband and she imposed a sense of worthlessness on her. She used to beat her up. When she was seven years old, her mother kicked her so hard that she had a broken rib, which was discovered later by accident, when she had a lung X-ray.

The patient stated that emotional insults were much harder than physical abuse, she even rated it numerically as 60% emotional to 40% physical abuse. Her mother used to tell her repeatedly that she was sorry to have given birth to her, how she would have been better off without her, that she was ugly, stupid and fat. With time she developed phobias of the dark, closed space and heights. At the age of eight, she started injuring herself by scratching till bleeding. The problems worsened when she changed school in 5th grade. Then she started wearing black clothes and listening to Nirvana, she would sit at the back of the classroom, alone and without friends. Her school marks got worse and she started gormandizing and was in constant conflict with her mother. That summer, she was so disinterested in everything

around her, that she only lay on her bed listening to music and eating, physically unable to get up. At that phase, she started injuring herself with cuts on the forearms and upper legs and burns by placing hands over a gas burner. Asked why she had done that, she answered: "to stop the inner pain". She felt such pain and pressure in her chest, she couldn't cry, so she injured herself to suppress the pain inside. After the therapy and her parents' divorce, when her mother left the house, her health improved. She started secondary school, found friends. Her mother was receiving therapy so now they have a "civilized" relationship, as she puts it.

Final phase of psychotherapy

Visits to the family physician became less frequent, the patient was no longer sullen. She was more cheerful and more interested in the real world.

She had visited the family physician eight times during the last year. The reasons were respiratory infections, low blood pressure, fatigue, sleepiness or some current issues which she wanted to discuss with her physician. The physician was observing her mood disturbances and giving her support, and when needed, coordinating teamwork with the psychologist, psychiatrist and social worker.

Discussion

This paper showed a case of an adolescent girl who developed depression connected to multiple family environment problems. The first step in proper treatment of depression is early recognition and proper diagnosis. Studies show that the prevalence of mental disorders in children and adolescents visiting family physicians is over 25%. Data also indicate that the majority of these disorders are not discovered at that level of care, and consequently are not adequately treated. [16]

Literature names many factors responsible for that, and most frequently those are somatisation and non psychological co-morbidity.[17] In the case presented, the patient also did not ask for help with her psychological or family problems. Retrograde analysis of the content of weekly visits which were scheduled for the end of the working day with the aim of therapeutic support, clearly shows that five years earlier depression had been diagnosed, the patient had revealed a number of factors which motivated the family physician on considering the bio-psychosocial approach. Frequent visits and vague symptoms like headache and uncertain abdominal pain without clinical or diagnostic findings, together with distress were signals to the family physician to consider psychic components to these problems, which made her intervene.[18] Literature shows that patients who visit their physicians more frequently are more easily recognized as patients with psychological problems.[19]

Somatisation, female sex, psychological problems and diseases are specified in many studies as predictors of family violence, as was the case in this study.[20,21]

The father, who was in care of the same family physician as his daughter, admitted to have had problems with his wife and mentioned mother-daughter problems only after a year of frequent visits to the physician. Fear of stigmatization, physician's rejection and belief that the family physician is not a person who would deal with family violence are reasons which prevent patients from telling their problems openly.[22]

In spite of many warning symptoms and frequent visits, conspiring of father and daughter not to reveal family problems to the physician whom they had known for a short time, and not knowing the mother, made the physician's intervention impossible for quite a long time.

The crucial moment for intervention in the case of this patient was the discovery of her self-harming. She started injuring herself with cuts on the forearms and upper legs, and burns by placing hands over gas burner. Asked why she had done that, she answered: "to stop the inner pain". She felt such a pain and pressure in her chest, she couldn't cry, so she injured herself in order to suppress the pain inside.

Primary health care is extremely important for early intervention because a family physician has a continuous therapeutic relationship with a patient and the whole family, which was obvious in this case. Despite consultations with a psychiatrist, the patient continuously sought and got her physician's support.[23]

Other depressive risk factors beside self-harm include: female sex, drug misuse, depression, anxiety, low self-esteem.[24,25] For the psychotherapeutic approach, very important factors for the family physicians are not only the patient's factors, but also the experience, attitudes and the style of a professional.[26]

The Balint method of group training helped the physician to recognize the psychological components in the physician-patient relationship, especially the unconscious level one. The physician's attitude encouraged the talk about existing problems, and advice, suggestions and team work with other relevant services stimulated healthy mechanisms for creating the patient's own future.[27]

Introducing the father into the therapy, as well as the patient's own complaints during the planned supportive talks, showed that self-inflicted injuring was a way of managing depressive feelings and of reducing the tension of the young person.[28,29]

Besides, the patient was repeatedly criticized by her mother, and it is also recognized that people who suffer abuse during their childhood can take over in a similar way self-criticism or some kind of self-abuse, which leads to a self-critical cognitive style and may finally lead to non-suicidal self-inflicted injuring.[30]

The patient's complex life circumstances are accessible only to a family physician because of the specificity of the family physician's work. This case clearly shows that depression must be considered in the context of biological, social, family and cognitive factors which affect an adolescent at any time.

The girl had a whole range of predisposing risk factors for depression, including mother's illness, deteriorated family relationships, multiple family violence, low support and deteriorated relationship with other family members.

She also showed a number of cognitive factors common for adolescent depressions: negative self-concept, passive coping style, cognitive distortion and the feeling of lack of control over negative life events.

The role of a well-educated family physician as a coordinator in team work and shared medical care is crucial in identifying and treating adolescent mental health problems.

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