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Major Depressive Disorder in the Adolescent – Barriers To Managing Adolescent Mental Health Problems at Primary Care.

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INTRODUCTION

**Major Depressive Disorder (MDD) among adolescents is increasing, and might lead to high-risk behaviors and suicide. Therefore, early identification is vital for immediate intervention. The primary care team acts as an intermediator in managing major depression, whereby parents and school officials play an essential role in achieving optimum recovery. This case report aims to acknowledge the importance of biopsychosocial support and unveil the barriers faced in managing adolescent MDD in primary care.

**This was a case of a female adolescent aged 14 years old, diagnosed with MDD after a comprehensive psychological assessment. She has been co-managed by specialists at the primary care and hospital psychiatry clinic. An intensive approach comprising patient-family counselling, school visits, patient self-empowerment, and regular hospital psychiatric clinic follow-ups for psychotherapy sessions shown a significant improvement in her mental health condition. Her mood is elevated; she shows interest in daily activities and can focus on classes.

**This case exhibited a high commitment to dealing with MDD in adolescents. We found four critical challenges in managing her: 1) To pick up the diagnosis of MDD earlier for immediate intervention. 2) Poor compliance with medication and defaulted follow-up. 3) Psychosocial issues related to the illness, such as personal and social stigma, lead to embarrassment and despair. 4) Inadequate family support with high academic expectations and school monitoring.

CASE REPORT

A 14-year-old teenage girl, a boarding school student with no previous medical illness, presented to the clinic complaining of epigastric discomfort and difficulty breathing for two days. There was no sour or globus sensation in the throat, nausea, vomiting, or loose stool. She was treated with acute dyspepsia. She visited the clinic twice in a week for similar complaints, mainly due to her inconsistent dietary habit. All examinations were unremarkable and all blood investigations in the normal range.

During 4th visit, her clinical presentation raised suspicion concerning a definite diagnosis. Further questioning regarding her psychosocial issue using Health Status Screening Form for Adolescents (BSSK) identified a 'risk' for mental illness. 'BSSK' is a short form of 'Borang Saringan Status Kesihatan' for screening adolescent health status for early detection of risk factors in mental health. A complete history taking towards mental health conditions was carried out. She admitted to having a low mood and losing interest in doing her daily activity for six months. It was associated with insomnia and fatigue. She loss focus during academic classes, resulting in poor academic performance. She started isolating herself and refusing to socialize with other friends. Further history-taking was done using the HEEADSS approach, **H**ome, **E**ducation, **E**ating, **A**ctivities, **D**rugs/ Substance, **S**exuality, and **S**uicide/Safety (HEEADSS) screening tool to obtain more related history (Smith & McGuinness, 2014).

After thorough assessment and examination, she was diagnosed with moderately severe major depressive disorder (MDD). Trigger factors may be multifactorial. Due to the illness, a family video conference was arranged to discuss further management and obtain consent for her treatment

She was arranged for 2-weekly follow up visits initially for monitoring of her condition, as well as for suicidal risk assessment. She participated in at least 4 counselling sessions as part of interventional mental health programs, involving cognitive behavioural therapies, stress coping mechanisms and stress diaries. Regular discussions among parents, teachers and healthcare providers was arranged to obtain a collaboration and psychosocial support in managing her. She was started on oral Sertraline 50mg daily, with additional monitoring and evaluation from adolescent psychiatrist.

Reassessment at the 20th-week followed-up shows an improvement from moderately severe score to a mild-to-moderate score. In addition, she was able to improve her focus during academic classes and has a positive social relationship with other students.

Outlines Of Non-Pharmacological Management For Depression In Adolescents

Cognitive Behavioral Therapy For Adolescent With Depression (Weersing & Brent, 2006)	Psychoeducation and mood monitoring : - Providing parents with information about the course and characteristics of depression and its treatment. - Teaching the adolescent to monitor their moods, thoughts and behaviours. Pleasant activity scheduling and behavioural activation: - To promote engagement in activities that provide opportunities for pleasure and mood regulation. Cognitive restructuring: - To help the adolescent to examine their automatic thoughts and assess the accuracy and practical consequences of their views. - To teach adolescents to engage in rational thinking about themselves, the world, and their possibilities for the future. Relaxation techniques to cope with continuing environmental stressors, providing social skills and conflict resolution training
Adolescent Stress Coping mechanism (Mason et al., 2019)	Diaphragmatic breathing Progressive muscle relaxation Low-cost exercise Personal diaries
Spiritual Empowerment	Islamic Integrated Meditation (Anchor, M., et al. 2015) . Five times per day for 5 to 10 minutes, sit in a relaxed position, eyes closed, and repeat a word (zikir) with each breath. Recite or listen to Qur'anic verses blend with controlled breathing.

DISCUSSION & CONCLUSION

Millions more children and adolescents experience psychological distress that may not meet the diagnostic criteria for a mental disorder but have significant impacts on their health, development and well-being (UNICEF, 2022). In this report, we observed a few barriers to managing her major depressive disorder at the primary care, which comprises failure to early detection of the mental illness, poor compliance with medication and defaulted follow-up, psychosocial issues related to the illness such as personal and social stigma, embarrassment and feeling despair, inadequate family support and school monitoring.

Early detection of depression among adolescents is challenging. The consultation skill from health care providers is essential for the timely diagnosis of depression (Asarnow et al., 2002). From this case study, we advocate regular screening using Health Status Screening Form for Adolescents (BSSK) for all adolescent patients attending primary care clinics particularly those are frequent attendees. A more complete evaluation and analysis based on HEEADSS can be integrated in history-taking facilitates identifying the underlying stressor and suicidal risk.

Integrated and multidisciplinary services are needed to expand the scope of possible interventions and to limit the risk of poor long-term outcomes, which is also an additional potential benefit in terms of healthcare system costs (Colizzi et al., 2020). This case highlighted the importance of a multidisciplinary team approach and good psychosocial support, primarily parental care, school officials' assistance, and peer group acceptance, to overcome barriers such as early diagnosis, patient compliance, personal and social stigma, and psychosocial support in managing mental health illness among adolescents toward achieving optimum care and recovery.

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MAJOR DEPRESSIVE DISORDER IN THE ADOLESCENT – BARRIERS TO MANAGING ADOLESCENT MENTAL HEALTH PROBLEMS AT PRIMARY CARE.

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ABSTRACT

Aims/Background:
Major Depressive Disorder (MDD) among adolescents is increasing, and it is an important health problem leading to high-risk behaviors and suicide. Therefore, early identification is vital for immediate intervention. The primary care team acts as an intermediator in managing major depression, whereby parents and school officials play an essential role in achieving optimum recovery. This case report aims to acknowledge the importance of biopsychosocial support and unveil the barriers faced in managing adolescent MDD in primary care.
Methodology:
This was a case of a female adolescent aged 14 years old, diagnosed with MDD after a comprehensive psychological assessment. She had visited the clinic a few times prior to the diagnosis for other acute problems, but MDD has never been picked up. She has been co-managed by specialists at the primary care and hospital psychiatry clinics. Her initial management included two weekly clinic follow-ups for clinical monitoring and counselling sessions with trivial improvement. Following an intensive approach comprising patient-family counselling, frequent school visits, patient self-empowerment, and regular hospital psychiatric clinic follow-ups for psychotherapy sessions has shown a significant improvement in her mental health condition. Her mood is elevated; she shows interest in daily activities and can focus on classes.
Results:
This case exhibited a high commitment to dealing with MDD in adolescents. We found four critical challenges in managing her: 1) To pick up the diagnosis of MDD earlier for immediate intervention. 2)Poor compliance with medication and defaulted follow-up. 3)Psychosocial issues related to the illness, such as personal and social stigma, lead to embarrassment and despair. 4)Poor family support with high academic expectations and inadequate school monitoring.
Conclusion:
This case highlighted the importance of a multidisciplinary team approach and good psychosocial support, primarily parental care, school officials' assistance, and peer group acceptance, to overcome barriers such as early diagnosis, patient compliance, personal and social stigma, and psychosocial support in managing mental health illness among adolescents toward achieving optimum care and recovery.

Keywords: Major Depressive Disorder, Adolescent, Multidisciplinary approach, Barriers

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