Literature Review on Prevalence, Risk Factors and Consequences of Adolescent Depression

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Abstract

One of the most prevalent problems of mental health is depression, which is a serious health problem among the adolescents population, and requires psychological support for the majority at adolescents. In many research studies, higher levels of depression have been reported to be predictive of various maladaptive psychological states and behavior. Depression is a common mental health issue commonly faced by children, adolescents, and adults and has numerous health, economic, and quality of life implications. Depression often emerges during adolescence (ages 12-18; Kessler et al., 2001) and recurs or persists into adulthood (Lewinsohn et al., 2003). Adolescent depression is increasing at an alarming rate (Backman et al., 2002). The DSM-5 criteria for Major Depressive Disorder are similar for adults, adolescents, and children. Depression in adolescence may represent differently than it does in adulthood (American Psychiatric Association, 2013). The theoretical models of depression have three components such as diathesis-stress model, self-esteem model, and Beck's cognitive models. Depression is a common mood disorder that affects individual functioning across different domains. It is includes major depressive disorders, dysthymia, and bipolar disorder. Clinical course of depression and suicide are mentioned in this paper and also explain social support, self-esteem and stressful life events.

Introduction

Depression is one of the most widespread diseases across the world and a major factor in problems of mental health. Today, depression is estimated to affect 350 million people. The World Mental Health Survey conducted in 17 countries found that on average about 1 in 20 people reported having an episode of depression in the previous year. Depressive disorders often start at a young age; they reduce people's functioning and often are recurring. For these reasons, depression is the leading cause of disability worldwide in terms of total years lost due to disability. Depression is a common mental health issue facing children, adolescents, and adults and has numerous health, economic, and quality of life implications. Depression often emerges during adolescence (ages 12-18; Kessler et al. 2001) and recurs or persists into adulthood (Lewinsohn et al. 2003). The consequences of depression during adolescence include and increase risk for various maladaptive behaviors, such as substance abuse and suicidal behavior, as well as interpersonal, academic, and psychosocial problems (Birmaher et al. 1998; Nolen-Hoeksema et al. 1992). Thus, adolescence represents a critical time to study risk factors that contribute to the development of depression. Currently, more adolescents are reported to suffer from mental health problems more than those in to the past. A number of studies have indicated a high prevalence of mental health problems among students, including depression, compared to rest of the population (Yusoff et al., 2013).

Therefore, it is important to understand concerns regarding adolescent's mental health. The purpose of this study is to estimate the prevalence of depression and its associated factors among adolescents. It is hoped that findings will be helpful to diagnose those vulnerable adolescents early to offer immediate treatment and to cater appropriate support.

Objectives of the Study

1. To describe the prevalence of depressive symptoms among adolescents.
2. To explore the relationships between risk factors and consequences of depression among adolescents.

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Conceptual Definition of the Terms

Self-esteem : Also called self-image and self-worth, an individual's overall view of himself or herself (Santrock, 2006).

Depression : A type of mood disorders in which individual feels worthless, believes that things are not likely to get better, and behaves lethargically for a prolonged period of time (Santrock, 2006).

Adolescence : Transitional period from childhood to adulthood, beginning around ages ten to twelve and ending around eighteen to twenty-two (Santrock, 2006).

Prevalence : For a representative sample, prevalence is the number of people in the sample with the characteristic of interest, divided by the total number of people in the sample. (https://www.nimh.nigh.gov>articles).

Literature Review

Literature pertaining to concepts, theories and pervious findings of depression are presented. Moreover, the correlates, and impact of depression such as prevalence, risk factors and consequences are also presented.

Adolescence

"Adolescence" is a dynamically evolving theoretical construct informed through physiologic, psychosocial, temporal and cultural lenses. This critical developmental period is conventionally understood as the years between the onset of puberty and the establishment of social independence (Steinberg, 2014). The most commonly used chronologic definition of adolescence includes the ages of 10-18, but may incorporate a span of 9 to 26 years depending on the source (APA, 2002).

Definition of Depression

Depression is typically thought of as a strictly biochemically-based or emotionally rooted disorder (Merikangas, He, Burstein et al., and 2010). Depression is a psychiatric disorder with the defining feature being a change from pleasant to unpleasant moods (American Psychiatric Association, 2013). For the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnosis of Major Depressive Disorder, five or more symptoms must have been present for at least two weeks. These symptoms include depressed mood, loss of interest or pleasures, weight loss/gain, insomnia or hypersomnia, psychomotor agitation, feelings of worthlessness, diminished ability to concentrate, and recurrent thoughts of death or self-harm (American Psychiatric Association, 2013). It is important to establish whether these symptoms have been accounted for due to the differentiation between depression and normal mood fluctuations and short responses to challenges in everyday life. It is also important to establish an understanding of the individual's mood to make sure the direct effects of the behavior are not due to substance use, a medical condition, or a recent death of someone close in their life. Any of these may reduce the likelihood of reliable and valid mental status assessment. The duration of a depressive episode can range from 2 weeks to several years. Episodes may also differ in their severity from mild, indicating only a modest deviation from normal functioning, to severe, involving an inability to care for oneself and requiring intensive care (American Psychiatric Association, 2013).

Adolescent Depression

Specifically, adolescent depression is increasing at an alarming rate (Backman et. al, 2002). Lifetime prevalence rates of depression in adolescents are estimated to range from 15% to 20% compared to adult lifetime rates (Kaminski & Garber, 2002).

The DSM-5 criteria for Major Depressive Disorder are similar for adults, adolescents, and children. However, depression in adolescence may present differently than it does in adulthood (American Psychiatric Association, 2013). There is longitudinal evidence from a study (birth-26 years old) that suggests that child and adolescent onset of depression may be distinguished from the adult onset of depression by childhood risk factors (Merikangas et. al, 2010). Some of these factors include developmental deficits, family dysfunction, instability, psychopathology, criminality in the biological family, and inhibited or uncontrolled temperaments in childhood (Milin, Walker & Chow, 2003). Early onset of depression has been shown to predict future depressive episodes throughout the lifespan (Milin, Walker & Chow, 2003; Yagnik, McCormick, Ahmad, Schecter, & Harris, 2014).

Depression in adolescence is typically long in duration with a high risk of relapse. Several studies have shown the mean length of a depressive episode to be 6 to 9 months (Milin, Walker & Chow, 2003). The longer the duration of the depressed episode, the greater likelihood of it persisting and recurring.

Theoretical Models of Depression

Diathesis-Stress Models of Depression

The model shown in Figure 1 will guide for discussion. This model, which is known as a diathesis-stress model (Monroe & Simons, 1991), identifies two general factors that influence the onset of depression. One of these factors is a negative life event (or source of stress). These events typically involve the loss of an important source of love, security, identity, or self-worth. The death of a loved one, the breakup of an important romantic relationship, or a significant personal failure is prototypic examples.

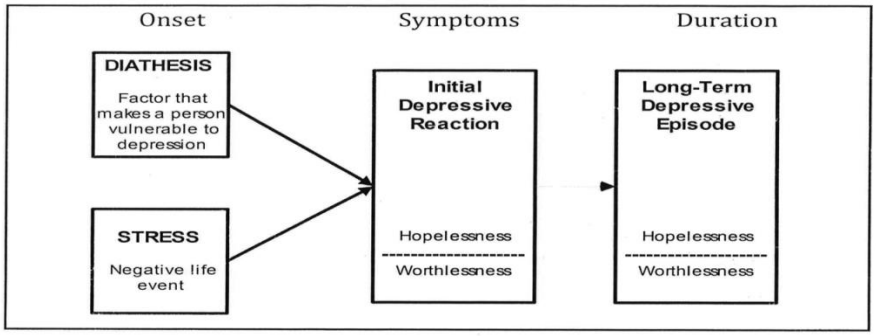

Figure 1. Schematic representation of a model of reactive depression

The link between events of this nature and depression was revealed in a landmark study by G. Brown and Harris (1978). These investigators interviewed over 400 women (ages 18-65) living in an area of London. Assessments were made regarding the presence or absence of depression in the preceding year and the nature and number of negative life events the women had experienced. Across the entire sample, 30 percent of the women reported experiencing a severe negative event or chronic difficulty in the nine months prior to the interview; among women who had experienced a bout of depression, this percentage jumped to 75 percent.

The data Brown and Harris (1978) gathered document that depression is often preceded by a negative life event. At the same time, the data also showed that only a minority of women who experienced a severe event became depressed. On the basis of these and other findings (Paykel, 1979), researchers now agree that negative life events precipitate depression in some but not most, people.

A diathesis is a vulnerability factor that influences how much damage a stressful experience creates. For example, the structural integrity of a building constitutes a diathesis. If

an earthquake comes, a poorly made building will suffer greater damage than a well-made building will. In a conceptually similar vein, researchers have sought to identify factors that influence whether people become depressed when faced with a stressful experience. As we will see momentarily, some of these vulnerability factors concern the way people think and feel about themselves.

Self-Esteem Models of Depression

Keith Dutton found that low self-esteem people suffer greater emotional distress when they fail than do high self-esteem people and that this occurs, in part, because failure leads low self-esteem people to feel bad about themselves (Brown & Dutton, 1995). These findings do not establish that low self-esteem people are at greater risk for developing depression, but they are consistent with this idea.

George Brown and his colleagues (Brown, Andrews, Harris, Adler, & Bridge, 1986) have offered even more definitive evidence that low self-esteem is a risk factor for depression. Initial support for this conclusion came from the study by Brown and Harris (1978). Brown and Harris found that many of the women who were depressed had previously experienced a stressful life event, but not all women who had experienced a stressful life event became depressed. Additional data analyses revealed that certain social characteristics increased a person's risk for developing depression. These included the early loss of one's mother in childhood and the lack of an intimate, confiding relationship in adulthood. Brown and Harris speculated that these factors put people at risk for developing depression by lowering self-esteem. In this model, then, prior social experiences involving the loss of a loved one or a lack of intimacy give rise to low self-esteem, and low self-esteem, in conjunction with a subsequent negative life event, increases the risk of depression (Brown and Bifulco, 1990). Figure 2 shows the model.

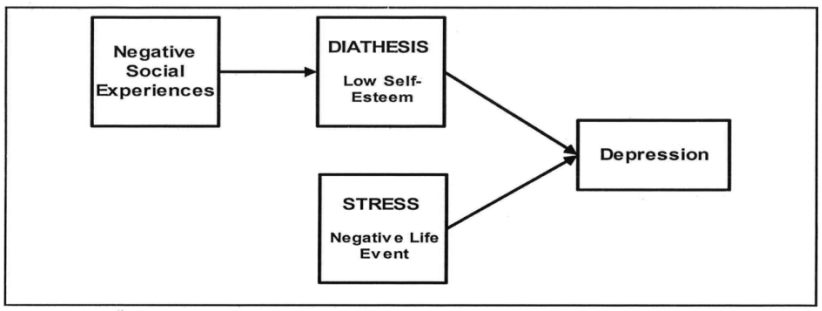

Figure 2. George Brown's model of self-esteem and depression

Self-Worth Contingency Models of Depression

Self-worth contingency models provide another perspective on the role of self-esteem in depression. These models begin by assuming that people strive to feel good about themselves (i.e., to satisfy their self-enhancement needs). People prone to depression have highly conditional feelings of self-worth. They feel good about themselves when certain conditions are met (e.g., they are in a romantic relationship; they are succeeding, at their work or schooling) but bad about themselves when these conditions are not being met. Depression arises, according to these models, when experiences threaten these "conditions of self-worth" and people perceive they won't be able to meet their self-enhancement needs in the future. Figure 3 shows the model.

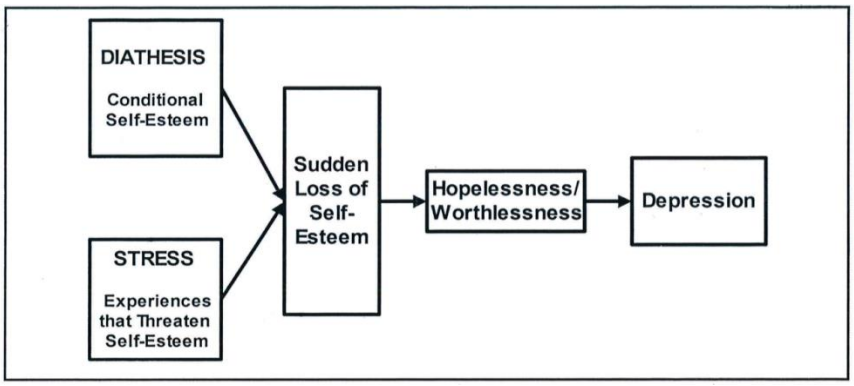

Figure 3. Self-worth contingency models of depression

Beck's Cognitive Models of Depression

Aaron Beck was one of the first theorists to advocate this position (Beck, 1967, 1976; Beck, Rush, Shaw, & Emery, 1979). As a therapist with an active clinical practice, Beck sought to understand the nature of depression in order to devise effective treatment strategies. Beck began by developing a precise description of the disorder, with special attention given to distinguishing primary symptoms from more secondary ones (Beck et al., 1979). As his work has evolved, Beck has added causal elements to his descriptive account of depression. Figure 4 presents a schematic representation of his theory, based on some of his most recent work (Beck, 1979).

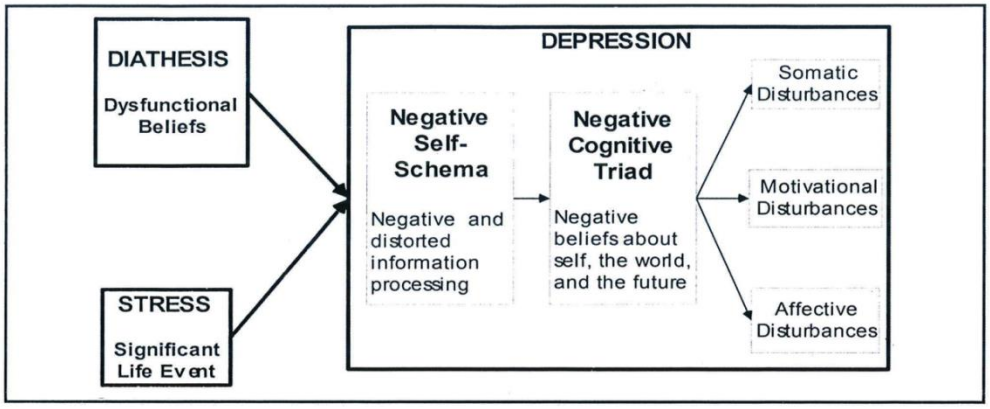

Figure 4. Beck's cognitive model of depression

Beck's most central assumption is that depression is principally a cognitive disorder characterized by three negative, self-relevant beliefs: (1)a negative view of the self (when depressed, people believe they are defective, deficient, and worthless); (2)a negative view of the world (when depressed, people are dissatisfied with their current life situation and believe the world is making unreasonable demands upon them); and (3)a negative view of the future (when depressed, people are pessimistic about their ability to attain desired outcomes). Beck refers to these beliefs (which encompass feelings of hopelessness and worthlessness) as the negative cognitive triad and assumes that they are the central feature of all types of depression. This means that other aspects of depression, such as somatic disturbances (e.g., trouble sleeping), motivational disturbances (e.g., passivity and withdrawal), and affective disturbances (e.g., intense sadness), arise in response to these beliefs (Beck et al., 1979).

Prevalence of Adolescence Depression

Depression is a common mood disorder that affects individual functioning across different domains. It is currently known that more than 350 million people suffer from

depression worldwide and that it significantly contributes to the global burden of disease (World Health Organization, 2012).

Navabi Nejad (2000) stated that among twenty eight (28) million children living in Iran, two millions of them are suffering from depression. Similarly, Bryant (2008) found that about 2.5% of all children and up to 8.3% of all adolescents in the United States suffer from depression. Although clinical depression is mostly seen in adolescents, very young children may also suffer from depression. Moreover, he stated that the high rate of depression among adolescents and the appearance of depression in very young children showed the need for research on depression among children, and therefore children will benefit the intervention programs which are designed based on the findings (Bryant 2008). The global point prevalence rate of elevated self-reported depressive symptoms from 2001 to 2020 was 34 %.

Depression in particular appears prevalent with estimates for Myanmar's adolescents (depression, 27.2%) at least five times that of Southeast Asian regional estimates (females 5.1%, males 3.8%) (World Health Organization, 2017). Southeast Asia bears the greatest share of global depressive disorder, with 27% of global cases occurring here (World Health Organization, 2017). This stands in contrast to Africa, with 9% of global cases, and Europe, with 12%. These findings underscore the need to address adolescent mental health in Myanmar, but also to invest in better data collection efforts (Asian Journal of Psychiatry, 2021).

The Depressive Disorders

The depressive disorders include major depressive disorder, dysthymia, and bipolar disorder. Major depressive disorder is the most common depressive disorder in adolescents, and depression refers to this form of depressive disorder. Major depressive disorder is present when either depressed mood or a lack of pleasure in usual activities is present continuously for 2 weeks or more and is accompanied by five or more additional symptoms (American Psychiatric Association [APA], 2000). Symptoms include changes in appetite, sleep, or weight; fatigue; decreased libido; difficulty concentrating; feelings of worthlessness; and, in moderate to severe cases of major depressive disorder, recurrent thoughts of death. The point prevalence for major depressive disorder in adolescents ranges from 0.4% to 8.3% and the lifetime prevalence is approximately 10% to 28% (Birmaher et al., 1996b; Lewinsohn, Rohde, & Seely, 1998a). Girls are twice as likely as boys to have major depressive disorder.

Dysthymic disorder (DD) also is seen in adolescents and is present when depressed mood is present every day for at least 1 year. It is accompanied by the same symptoms seen in major depressive disorder and feelings of hopelessness and low self-esteem, but it does not meet the full criteria for major depressive disorder. Adolescents with DD are at high risk of developing major depressive disorder, and when this occurs, it is referred to as double depression (Cicchetti & Toth, 1998).

Approximately 10% to 15% of adolescents with recurrent major depressive disorder will subsequently develop bipolar disorder (APA, 2000). In bipolar disorder, both mania and MDD are part of the illness spectrum. Mania is characterized by an expansive or irritable mood accompanied by an inflated self-esteem, decreased need for sleep, extreme talkativeness, and flight of ideas. In adolescents, school failure and truancy, antisocial behavior, and substance abuse may be present (APA, 2000). Typically, a manic episode immediately precedes or follows the depressive phase of the illness.

Clinical Course of Depression in Adolescents

The symptoms of Major Depressive Disorder (MDD) in adolescents mirror those of adults but generally are milder. Symptoms may appear as weight/appetite disturbances and

feelings of worthlessness and guilt in adolescent girls (Lewinsohn et al., 1998a). Adolescents are likely to have their first episodes of major depressive disorder at about age 15 (Kovacs, 1996). For girls, the first episode of MDD is likely to occur at menarche. There is a higher risk of major depressive disorder in girls who have early or late menarche. In adolescents, the typical episode of MDD lasts between 2 and 9 months. Adolescents who have their first episode early in puberty are more likely to have more severe episodes that last longer (Lewinsohn et al., 1998a). Major depressive disorder that occurs in adolescents is likely to be recurrent (Sampson & Mrazek, 2001). The probability of recurrence is 40% by 2 and 70% by 5 years (Birmaher et al., 1996b).

Estimate of comorbidity with MDD in adolescents ranges from 40% to 70% (Birmaher et al., 1996b). Adolescents with major depressive disorder also commonly have DD, anxiety disorders, disruptive disorders, and substance abuse. The anxiety and disruptive disorders tend to appear before major depressive disorder, whereas substance abuse tends to appear several years following the index episode of MDD (Cicchetti & Toth, 1998). Comorbidity complicates the treatment of MDD and is associated with recurrent episodes and suicide attempts. It also is associated with more impairment in functioning, academic problems, and more conflict with parents (Lewinsohn et al., 1998a).

MDD in adolescence can affect school and social functioning. Some but not all investigations show declines in academic performance and school difficulties (Birmaher et al., 1996b; Flament et al., 2001; Rickert et al., 2000). Of some concern is the association of MDD with adolescent risk behavior. Initiation of smoking based on peer pressure is more common among those with depressive and anxiety symptoms (Patton et al., 1998). In another study, MDD predicted the onset of smoking among adolescents (Brown, Lewinsohn, Seeley, & Wagner, 1996). Rickert et al. (2000) showed that depressed adolescent girls were more likely to binge drink and get drunk, drop out of school, smoke, and be physically or sexually assaulted. Another study showed that adolescent risk behaviors were prevalent and aggregated in both boys and girls with depressive symptoms (Tubman, Windle, & Windle, 1996). A survey study examined the relationship of carrying a weapon with other adolescent risk behaviors (Kulig, Valentine, Griffith, & Ruthazer, 1998). Carrying a weapon was associated with using marijuana, having sexual experience, witnessing a crime, desiring to beat up someone, and skipping school. It is alarming to note that these risk behaviors also were associated with a significant increased risk for thinking about or wanting to harm oneself.

Rick Factors of Adolescence Depression

Suicide

Suicide is the third leading cause of death among young people ages 15 to 24 years. Among adolescents ages 15 to 19, the suicide rate was 9.5 per 100,000 or a total of 1,802 successful suicides (U.S. Department of Health and Human Services [USDHHS], 2000). Boys are 5 times more likely to commit suicide than are girls. Among African American males ages 15 to 19, the rates of suicide have increased rapidly. From 1980 to 1996, the suicide rate among Black males more than doubled, from 3.6 in 100,000 to 8.1 in 100,000 (National Center for Health Statistics, 1999), an increase of 105% (USDHHS, 2000). Homicides are prevalent among African American males and may reflect suicidal behavior (Daugherty, 1999).

Death by fire arm accounts for 63% of the increase in suicide among adolescents. The vast majority of these (67%) obtain the gun in their home (Shah, Hoffman, Wake, & Marine, 2000). Alcohol also plays a role in suicide completion among adolescents. States that have set the minimum drinking age at 18 have higher rates of suicide than those whose minimum is 21 (Birckmayer & Hemenway, 1999).

Suicide attempts and suicidal ideation are also common among adolescents. The suicide attempt rate among adolescents is estimated at 2.6% (USDHHS, 2000). Suicide attempts are most common among girls (3.3%) and Hispanics or Latinos (2.8%). About a quarter of adolescents report suicidal ideation, and 15% report having a plan to commit suicide (Rey, Narring, Ferron , & Michaud, 1998). The risk factors included many factors such as drugs abused, smoking, alcohol drinking, etc..

Stressful Life Events

Major depressive disorder is a relatively common but severe illness associated with significant impairment in functioning. Many different types of stress are risk factors for depression. Episodic stress refers to discrete stressful life events that have a beginning and an ending (Hammen, 2005). Episodic stress is classified according to severity. Severe stressful life event includes events such as divorce, death of a close family member, and job loss. Severe events do not include more minor disruptions such as a break-up following a brief romantic relationship, a friend moving out of state, or failing an exam. In contrast to episodic stress, chronic stress refers to ongoing stressful life experiences, such as marital problems, financial strain, and ongoing parent-child relationship problems.

Certain life events appear to be relatively potent triggers of depression. For instance, there is abundant research linking interpersonal loss events such as deaths, divorce, break-ups, separations, and threats of separation to depression (Hammen, 2005).

Gender Differences

In many cultures, it is more acceptable for women to show their distress by crying, while men often express their emotions through anger or aggression and could therefore be less likely to see them, or be seen by others, as depressed (Lisa A. Martin, Harold W. Ngighbors and Derek M. Griffith, 2013).

Women and girls have a different experience of life from men and boys. For example, they are more likely to experience certain types of trauma such as domestic or sexual abuse (Office for National Statistics, 2018). According to several international studies in the background of childhood depression in addition to genetic and biological factors psychosocial and environmental factors also play an important role. Among the socio-demographic factors age and gender have an influence on the symptoms of major depression (Angold et at., 1998, 2002). The boy and girl ratio is nearly equal with slight male dominance in childhood at the same time in adolescence the number of depressed girls is double of that of boys (Angold et al., 2002, Birmaher et al., 1996).

Social Support

The presence of social support systems benefits those with depression and stress. Social support is broadly defined as the perception and experience of being valued and loved by other and the feeling of belonging to a larger social network (Wills, 1991). Social supports may be beneficial because they provide tangible goods (e.g., money), shared labor, intimacy, advice, feedback, and positive social interactions (Barrera, 1983). As expected, a lack of social support can harm one's psychological well- being. Low levels of social support are correlated with higher levels of depression (Lakey & Cronin, 2008).

Self-esteem and Vulnerability to Depression

Self - esteem was defined as a one-dimensional construct (Rosenberg, 1965, 1989) or as a two-dimensional construct (Mruk, 1999) conceptualized as including two components-self-worth and self-competence). As far as the dynamic of self-esteem, literature presented it as a personality trait stable across time within individuals, but influenced between certain limits

by many factors (Englert, Weed, & Watson 2000) or as a dynamic, changing construce (Baldwin and Hoffmann, 2002).

Self-esteem can serve as both a protective factor and as a risk factor in the development of mental health problems. Positive self-esteem can be a protective factor that contributes to positive social behavior and act as a buffer against the impact of negative influences (Mann et al., 2004). It is associated with mental well-being, adjustment, happiness, productivity, coping, success, and satisfaction (Baumeister, & Krueger, 2003). By example, high self-esteem may protect against depressive symptoms by decreasing the impact of negative thoughts (Orth, Robins, & Meier, 2009). Alternatively, negatives self-esteem can play a critical role in the development of a number of mental disorders and social problems, including depression, anxiety, anorexia nervosa, bulimia, violence, substance abuse, high-risk behaviours, and borderline personality disorder, in addition to feelings of hopelessness, suicidal tendencies, and attempted suicide (DeHart, Pelham, & Tennen, 2006; Mann et al., 2004).

Consequences of Adolescence Depression

Poor health behaviors are associated with depression and social challenges. In addition to an increased risk of suicide, youths who are depressed higher risk for mental disorders, conduct disorders, substance abuse, etc.. They are also more likely than other youths to engage in unsafe sexual practices and other risk behaviors. Behaviours that impact on the overall health and wellbeing of an individual are termed ‘health risk behaviours’ that is, they increase a person’s risk of developing ill health.

Depression has many negative effects and associated with emotional problems poor academic achievement, low level of exam performance, decreased attention, drug abuse, over consumption of alcohol and increased levels of smoking (Sobocki, Lekander, Borgstrom, Dtrom & Runeson, 2007, Chen et al., 2013). It is believed the major problems in students’ depression include poor self-assessment, loss of interest in sex, lack of pleasure and interest in everyday life, problems in eating and sleeping, and suicidal thoughts (Arslan et al., 2009).

Orton (2008) studied on depression among youth aged 7-14 years in America and identified that among children suffering from depression, the symptoms include bad temper, lack of interest in activities, losing weight, sleeping problems and fatigue, feeling of worthlessness, having problem in concentration, lack of self-confidence, negative thinking and being irrational.

Conclusion

Adolescence is an important period in developing knowledge and skills, learning how to manage emotions and relationships and acquiring attributes and abilities for adulthood. Depression in adolescence is a common mental health disease with prevalence of 4 to 5 percent in mid and late adolescence, Depression in adolescence can be a complex diagnosis and requires individual and oriented treatment. Major risk factor are suicide and self-esteem.

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