ENGAGING THE HELP-REJECTING DEPRESSED ADOLESCENT
FIRST INTERVIEW

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In your first interview with a depressed adolescent, the goal is interaction that assures continued assessment and collaborative care. In this article, we present a conversation that introduces the patient to therapy and shared decision-making.

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Recognition of the prevalence of adolescent depression has increased pediatricians’ interest in diagnosing this condition. Recent guidelines encourage screening for depression (for guidelines and other resources, see the table on page 44), but these guidelines do not discuss how to engage the depressed adolescent. They give the impression that the pediatrician need only know the diagnostic criteria and treatment algorithms. Such an approach gives little consideration to the process of engaging with the patient.

Pediatricians, like other physicians, will often find depressed adolescents difficult to engage. These patients are less likely to come self-referred than to be brought by a concerned parent or referred from school (eg, after completing a depression screening). The physician assessing such patients must be prepared for a challenging presentation.

In this article, we describe an interview between a pediatrician and an irritable adolescent who has failing grades. The immediate goal is engagement, such that ongoing assessment and collaborative care may be possible.

**The interview**

Mary L, a 15-year-old high school sophomore, is brought to my office by her mother (Mrs L). The office staff, alerted by Mrs L’s suggestion that Mary’s complaint may be depression, tentatively scheduled three 30-minute appointments over the next 3 weeks. The office staff scheduled the appointments for the half-hour immediately before my lunch break, because they’ve learned that these appointments often run over, and they would rather shorten my lunch than have a series of patients seen late.

I initially interview Mary and her mother together. Mary, scowling, comes into the office under protest.

Mrs L reports that over the past 6 months, Mary’s grades have fallen from As and Bs to Cs, she is doing less with her friends, and she “snaps back” when asked to help or even when asked how things are going.

“On TV they say she may have a chemical imbalance and needs medication,” Mrs L concludes.

“T’m not depressed!” Mary retorts.

I am already thinking of depression, but to pursue that question, I will need more information.

Before seeking additional history, I have a dilemma. Mary is angry and alienated and rejects the idea of depression. To pursue questions about depression—her mother’s definition of the problem—would seem to endorse her mother’s view and shut Mary out. That could derail assessment.

The other risk would be to miss my own response—the irritation and helplessness that come when patients push us away. As I start to feel irritation, I look for a conciliatory approach, rather than falling into coercion or withdrawal or even blaming a needy but balky youth.

I say, “I guess coming here was your mother’s idea, not yours, Mary. Did you feel dragged here?” I deliberately use informal language.

“Totally dragged, against my will,” replies Mary. “She’s impossible to please. And I’m not going to talk.”

I reply, “That’s fine. Don’t say anything until you want to.”

My first intervention has succeeded: Mary is speaking. If the patient did not begin speaking here, I would offer her a chance to listen while I talked further with her mother. I would make clear that I want to hear her story, but in a way that works for her.

In this instance, I say, “In that case, I could hear more from your mother. Would you mind listening? Jump in if your mother says something you disagree with.”

At least 2 other approaches are possible here. Some clinicians might ask Mary to wait in the other room while they talk with her mother. But I do not wish to exclude...
Mary, and I want to hear more while both are present.

Another response would have been to note Mary’s complaint — “brought against my will!” — and to ask whether she feels coerced in other ways. But such an inquiry would push exploration of a sensitive matter before the girl has even agreed to talk.

“That’s fine with me,” Mary says curtly.

Mrs L. relates that Mary has enjoyed good health, many friendships, and academic success and that she has played sports. There have been no obvious precipitants to her change in mood. In addition to Mary and her mother, the household includes Mary’s father, who is a successful businessman, along with a high-achieving older brother and a younger brother who is a star soccer player. All are in good health. The father “may have had a depression” as a teenager; Mrs L. is not sure. Family tension with Mary is considerable; on one occasion, Mrs L. slapped Mary.

Mary listens to her mother; her scowl softens a bit.

By this point, some teenagers would have interrupted their mother. For them, such participation-under-protest would be a move toward engagement. But, as Mary is not speaking, I ask for her point of view, continuing to use informal language: “Mary, what’s your take on what your mother has said?”

In the meantime, I have learned that a first-degree relative may have had a major depression. Her mother has not volunteered information about other depressive symptoms in Mary. I note Mrs L.’s readiness to speak in terms of a psychiatric disorder rather than use pejorative terms such as laziness, stubbornness, or bad behavior. There are no other problems in the family, Mrs L. adds.

Mary rolls her eyes, sighs, and says, “She never gets it; things aren’t so great at home.”

Clinicians might take various approaches here. Some might ask Mary to elaborate on this complaint and try to start conversation between mother and daughter. But Mary seems to have little confidence in her ability to manage a conversation with her mother. I tell both that I need more history but want to talk with Mary alone now. I ask Mrs L. whether there is any other information she wants to share before going out. She says no.

Alone, Mary says she is glad to be able to talk by herself. For several months, she says, more than people have realized, she has not felt herself. She no longer enjoys hanging out with her friends, finds longtime friends painfully immature, finds her courses boring, and, after a disappointment last year, has no interest in having a new boyfriend. She says that her sleep, energy, eating, and weight have not changed. She thinks fleetingly each day that she would be better off dead, but she says she does not think of suicide, nor does she have a plan to hurt herself. To acknowledge her distress and expand what we are talking about, I ask Mary to complete a depression questionnaire widely used in screening for depression, the Personal Health

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Questionnaire (PHQ-9); her scores suggest moderate depression. She says she smokes marijuana occasionally, but she denies alcohol use.

Mary denies feeling physically unsafe at home and says she has not been abused or molested. Asked about sexual orientation, she describes herself as straight. She rejects the idea that she may “have a depression,” adding, “That’s what my mother says I have when she doesn’t want to listen to me.”

Mary has provided considerable information. She meets Diagnostic and Statistical Manual of Mental Disorders, 4th ed (DSM-IV), criteria for major depressive disorder. But diagnosing a condition is not the same as making a connection with a person, and premature announcement of a diagnosis may interfere with our budding relationship. Mary has passive suicidal ideation but no active suicidal ideation or plan. The level of risk seems short of what would require hospitalization. Although her substance use history may be incomplete, it appears that a major risk factor for suicide, alcohol or substance abuse, is not present. Homosexual orientation, another risk factor, also appears not to be an issue in this case.

Other data are needed. For instance, the family psychiatric history will reveal who has had a mood disorder, whether particular agents have been helpful, and whether anyone has had restless sleep, agitation, and insomnia (so-called “activation”) or become hypomanic on antidepressants. Such data would point to genetic vulnerability in Mary. They would also provide an opportunity to ask about the terms “depression” and “psychiatric treatments” mean in Mary’s family. I also need to have a conversation with Mary about why she rolled her eyes when her mother said there were no problems in the family.

But Mary is not ready to discuss therapeutics. She balks even at the term “depression.” Like other teenagers (and many adults), she rejects a formal diagnosis and probably prefers terms like “having a difficult time” or “feeling out of sorts.”

I am confronted here with a dilemma. Mary’s rejection of a medical diagnosis might be construed as denial or resistance and the physician seen as ethnically obliged, when dealing with a serious, treatable disorder, to give patient and parent the diagnosis. This approach reflects a paternalistic model of the doctor-patient relationship, in which the patient presents with symptoms and the doctor provides information and remedies. However, Mary’s alienation is the immediate challenge. Any intervention short of involuntary hospitalization will be possible only if she accepts a diagnosis and plan.

Accordingly, before making a plan together in the spirit of shared decision-making, I judge that shared diagnosis-making—more broadly, shared meaning-making—is needed. That is, I have to find out whether Mary and I can find a way that works for both of us to talk about her trouble.

I tell Mary that I understand that “depression” does not seem like the right word for her trouble.

Mary seems surprised by my readiness not to insist on the diagnosis her mother has been pushing. “I guess I’m just feeling stressed out,” she says.

To Mary, “depression” means that she is sick and needs to take medication, that she is the only one in the family with problems, and that nothing else needs to be discussed. She has already alluded to painful but unspecified tensions at home.

Mary’s negative view of “depression” may itself reflect the self-blame and lowered self-esteem of major depression. But it may also be the cry for help of a teenage daughter whose mother can more readily assume her child has a psychiatric disorder than talk about other troubles at home (including topics difficult to discuss, such as conflicts between parents, anger dyscontrol, or substance abuse or depression in a parent).

Mrs L’s “enlightened” attitude toward mental illness and its treatment is not working for Mary. Mrs L’s attitude may not be free of stigma. In such families, it is important to consider cultural attitudes toward teenage unhappiness, mental illness, interpersonal conflict, and family troubles.

I will still need to talk with Mrs L about the family context and hear Mr L’s perspective on the situation.

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trouble and as a basis for planning—with shared acknowledgment between her and me (and, before the end of the interview, with her mother) that the term does not exclude other kinds of trouble in the family. She agrees to call me if her distress increases before her next office visit, especially if she feels like hurting herself.

I must ask the mother about her own level of stress and possible depression. Information about Mr L’s adolescent depression and his response to treatment will be helpful in considering potential medications. I must also help Mary’s mother realize that despite the claims of advertising, medication alone is neither an adequate nor an instantaneous cure for adolescent depression, and that if medication is prescribed, concomitant therapy can increase its effectiveness and decrease the possibility of the increased suicidal ideation that sometimes follows the prescribing of antidepressant medication. It is also important to help Mary’s mother see that, although I have not prescribed medication on this visit as she wished, we have accomplished much in our first meeting: she and Mary both agree that there is a problem, they are both willing to work toward a fuller understanding of it, and they are both motivated to make things better.

At the next meeting I will assess Mary’s state and her evolving attitude toward help. We will discuss the choice of treatments, both pharmacologic and psychological. These are difficult decisions, as there are only limited data regarding the effectiveness and the risks of antidepressant medications in pediatric patients; additionally, the best-researched psychosocial interventions, especially cognitive-behavior therapy, may have limited availability.²,⁴

Pending that meeting, I can offer nonspecific recommendations (physical activity, connecting with friends as able, setting reasonable goals, and staying away from drugs and alcohol).²,³,⁴

In this initial interview, I had 3 goals. The first was to assess the patient’s level of risk and determine the level of care she needs right now. The second was to make a preliminary diagnosis. The third was to make a connection with the patient, to mitigate her isolation, and to relieve the pain that she feels at having a condition definable only in terms that are unacceptable to her.
Commentary
This case illustrates that adolescent depression, a problem of major public health and clinical importance, need not present only with depressed mood and neurovegetative symptoms (such as decreased energy or altered sleep or appetite) but can present with irritability, defiance, and impaired school functioning. Especially in adolescents, depression may be accompanied by patient reluctance and even rejection of help. Nevertheless, the patient, parent, and physician must negotiate a definition of the problem before shared decision-making can begin. 3

Without such negotiation, premature diagnostic closure carries several special risks with depressed adolescents. Presentations of adolescent distress, even severe distress, may not carry the same predictive validity as in older patients. An adolescent storm may be just that. Most adolescents, wanting to see themselves as “okay” and “in control” of their lives, may feel threatened by a medical diagnosis, especially of a socially stigmatized disorder. For many adolescents, a diagnosis may be rejected when endorsed by a parent with whom the adolescent is already engaged in a struggle. Medical paternalism (even if the diagnosis is “accurate”) may align (in the adolescent’s eyes) with a parent who needs to be opposed.

The process of negotiating not only the treatment options but also the words to use for the problem occurs in all areas of medicine. But finding a shared language of acknowledgment and planning is especially critical when dealing with troubled adolescents. 25

REFERENCES