Data Trends

Summaries of research on mental health services for children and adolescents and their families

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Wisdom, J. P., Clarke, G. N., & Green, C. A. (2006). What teens want: Barriers to seeking care for depression. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(2), 133-145.

Jaycox, L. H., Rosenbaum Asarnow, J., Sherbourne, C. D., Rea, M. M., LaBorde, A. P., & Wells, K. B. (2006). Adolescent primary care patient's preferences for depression treatment. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(2), 198-207.

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In 2003 the President's New Freedom Commission on Mental Health recommended screening for child and adolescent mental health problems in the primary care setting. Yet rates of recognition of mental health problems in primary care settings remain low. According to Jaycox et al., primary care providers recognize mental health problems as "present or possibly present in only 12% of youth" (p. 199). When symptoms are recognized, primary care physicians provide "assessment, diagnosis, determination of need for care and care coordination" (Wisdom et al., p. 133), along with counseling and medication therapy. However, recognizing depression in teens and treating them can be difficult. Teen concerns about confidentiality and developmentally appropriate self-image issues may hinder teens from talking about their problems. Thus, these articles report on two studies of teen "attitudes and preferences toward treatment" (Jaycox et al., p. 198) in primary care settings. Lessons learned are of value to mental health workers and therapists.

In the first article, by Wisdom et al., findings revealed that teens respond to mental health treatment in a primary care setting when providers "actively considered and reflected upon the teenager's developmentally appropriate desires to be normal, to feel connected, and to be [autonomous]" (Wisdom, p. 133; see sidebar). Using a modified grounded theory approach, the authors conducted a focus group (n = 7) and in-depth interviews (n = 15) with teens aged 14-19 who had a diagnosis of depression, dysthmia, or depression not otherwise specified. Most respondents were Caucasian. Teens were classified into one of two categories: (a) received a diagnosis of depression, no treatment, and (b) received a diagnosis of depression, received treatment. Some teens had used antidepressant medication. Teens were first asked broad questions about their experience with mental health treatment, or barriers to receiving treatment, and more specific questions followed, based upon previous responses.

I thought about [talking to a doctor] a little but I pretty much had told myself that really I was just stupid and it wasn't something that needed to be looked at like that, that I was just over-reacting to things...I didn't want somebody to look at me and say 'What are you thinking?' I was highly afraid of somebody telling me that what I was feeling wasn't right, that I shouldn't be feeling this way (19 year old untreated female). (Wisdom et al, 2006, p. 138)

Yeah, I'd like [providers] to discuss more with me about why they think [depression] is happening to me, or what they learn in talking to me, because in speaking to them, I don't know if they're learning anything so I don't know if it's really a waste of time to speak to them because they don't give me any feedback (18 year old treated male). (Wisdom et al. 2006, p. 139)

[To physicians] I wouldn't always say jump straight to the medication, I would say definitely talk to them, tell them what's going on, what changes they're going through, especially when they're younger, talk to them about their changes physically and emotionally and definitely talk to them about depression and go in depth (19 year old untreated female). (Wisdom et al, 2006, p. 140)

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The most prevalent theme to emerge was that teens desire to be normal. In some cases, teens downplayed their symptoms in an attempt to rationalize that they were normal, or they worried that they would be perceived as not being normal, or as being "weak." Some teens did not want to have a mental health "identity," while other teens understood that depression was something they *have*, and not something they *are*. Most teens rejected the possibility of medication because medication ran counter to their ideas of normalcy.

Themes of connectedness and autonomy also emerged from the interviews. For example, teens want to know that they can confide in their doctor without having to worry about confidentiality issues. But providers also need to connect with the teen by providing feedback, empathy, and information about their depression. Finally, teens want to maintain their autonomy. "Not having a voice in their treatment, or getting little information about what was happening was particularly distressing" (Wisdom et al., p. 141).

The second study, by Jaycox et al., asked teens about their preferences for treatment. Teens (N = 444) were between the ages of 13-21, and most were Latino. All teens had screened positive for depression, but were "generally not seeking treatment for depression" (Jaycox et al., p. 205). Teens were asked, "If you were very sad, blue, or depressed everyday for more than a month, and could choose with your doctor how to be treated, what [of the following scenarios] would you choose?" (Jaycox et al., p. 200). Possible answers included: (a) daily medication for 6-9 months with a 60-75% chance of improvement within six weeks (medication); (b) weekly counseling with a therapist for three months with a 60-75% chance of getting better within three months (counseling); or (c) checking in with your doctor once a month, with a 30-45% chance of getting better without treatment and making a decision about treatment at a later date (watchful waiting).

Results revealed that half (50%) of teens preferred counseling, 22% preferred medication, and 28% preferred watchful waiting. Being female and having anxiety symptoms at the time of the interviews predicted a preference for active treatment (i.e., medication and/or counseling). Compared to Caucasians, African American teens were likely to choose counseling over medication. Further, teens who had negative attitudes about medication were unlikely to chose medication as a treatment option. However, teens with negative attitudes about treatment in general were likely to prefer medication.

In conclusion, "depression in adolescents is a major public health problem. By the age of 18, roughly 20% of our nation's youth experience a depressive episode" (Jaycox et al., p. 198), and "almost all who experience depression as adolescents experience another episode as an adult" (Wisdom, p. 133). Teens with depression are at risk for poor school and social performance, substance abuse, nicotine dependence, and suicide. Physicians (and mental health workers) who screen for depression need to be sensitive to teens' desires to feel normal, connected, and autonomous. Teens need to feel that they are being listened to, that their conversations are kept confidential, and that their concerns are taken seriously. Further, they desire accurate, timely information about depression, its treatments, and about normal developmental processes. Teens also desire to have a say in the kind of treatment they receive, including counseling, medication, or watchful waiting. See *Data Trends 15, 34, 36, 45, 72, 88, 93 & 96* for more information on the prevalence of depression, on depression-related suicide, and on child and adolescent psychotropic medication use.

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