Youth depression in Australia.

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According to the World Bank and the World Health Organization, unipolar depression is currently the first cause of disability worldwide in developed countries. In terms of years lost to death and disability, it is currently ranked fourth and predicted to be second only to cardiovascular disease by 2020.\(^1\) The trends in Australia are also of concern, where lost productivity due to mental illness now stands at $34 billion per annum, with treatment and rehabilitation costs of $4 billion. Depression is now Australia’s most debilitating illness, accounting for 8% of all years lived with disability and with an annual cost of $3 billion. Representing over 22% of aggregate losses, depression has the highest health, economic and social capital attrition burden to Australia of any disease group.\(^2\)

This paper will critique the burden of youth depression as a primary health issue in Australia. It will begin with a discussion of the impact of youth depression, on both an individual and community level, and its association with other mental illnesses, adult forms of the disorder and the youth suicide rate. An analysis of the origins of depression will follow, which are multi-causal and may be environmental, biochemical, evolutionary or socio-political in nature. MindMatters is an Australian initiative conceived to promote youth mental health and prevent psychiatric disorders and this paper will conclude with a discussion of the strengths and limitations of MindMatters in the context of youth depression.

The individual and social impact of depression is immense. Mental disorders account for 74% of the non-communicable disease burden and 55% of the total burden in young people.\(^3\) Depression disrupts physical health through a range of immune and nervous system mechanisms. It results in lower academic achievement, school absenteeism, aggression, attention disorders, peer relationship problems and impairments in general social competence. Epidemiological research has consistently identified adolescent-onset depression as having high rates of recurrence, progression and chronicity into adult forms of the disorder.\(^4\) Subsequent maladjustment may include poor functioning in relationships and family, elevated risks of hospitalisation,
poor vocational adjustment and reduced employment prospects, social isolation, violence, crime and lower global functioning and overall life satisfaction. There is also an established trajectory from mood disorders such as depression to health-risk and socially damaging behaviours, including alcohol and tobacco consumption, obesity and substance misuse.

In the developmental spectrum, the transition period between pre-puberty, adolescence and young adulthood is the peak time for the onset of depression, with most common mental health disorders commencing before 18 years of age. Depression frequently occurs with other psychotic disorders, including anxiety and schizophrenia, which have their onset between the ages of 15 and 34. Depression also has a high association with the youth suicide rate in Australia. Between 40 and 80% of teenagers with depression experience suicidal thoughts, with depressed teenagers 11-27% more likely than their non-depressed counterparts to kill themselves. Psychological autopsy reports indicate that 50% of people who commit suicide are suffering from depression at the time of death. Although statistics frequently underestimate the genuine situation, as death by suicide is not always identified, the official suicide rate in Australia is currently 2,500 per year, greater than the national road toll. After motor vehicle accidents, suicide is the leading cause of death in the 15-24 age group. Although females have higher rates of suicidal ideation than males and are twice as likely to attempt suicide, suicide rates for males aged 15-25 have more than tripled in the past 40 years. In each age group successive to World War Two, there has been an increase in the rate of depression-associated disorders and suicide. Overall youth suicide levels have tripled since the mid-1960s, from 10 per 100,000 to 30 per 100,000.

Females are diagnosed with depression at approximately twice the rate of males. It has been suggested that hormonal changes predispose adolescent females to depression. Alternatively, the depressive symptomatology of ‘self-harm, anxiety and eating disorders’, it is argued, is consistent with the passive and restricted behaviours imposed by the female gender role. In Australia, cultural expectations of masculinity may mean boys are socialised more into conduct disorders. It has, however, been suggested that extent of depression may be significantly underestimated in boys. The observation has been made that most young male
delinquents ‘have clear features of depression, including extremely low self-esteem, self-harming behaviours … and placing themselves in situations where they are exposed to violent attacks’. 

Depression is a complex and heterogeneous disorder and there is no unified theory as to its origins, which may be multi-causal. Environmental perspectives posit that individual cognitive and psychosocial elements explain depression, including personal disposition, social situation, adverse life events, attitudinal variables and a deficit in social support. Adolescents today have greater exposure to substances such as alcohol and illicit drugs, which can also trigger depression. It has been suggested depression is genetic or biochemical, arising from malfunctioning neural circuits or neurotransmitters, the chemicals which are used by nerve cells to communicate. Challenging the biomedical model, evolutionary biologists locate the constructs of health and disease within evolutionary history. They posit depression is simply a heightened response to adversity and a normal human functioning.

An alternative, controversial theory is that depression is a ‘manufactured epidemic’, a ‘shorthand label that has been dreamed up to medicalize a probable range of problems of living or, problems of being’. The diagnosis of ‘depression’ did not exist prior to 1900, when ‘depressive tendencies’ would have been considered melancholia or sadness. The aggressive promotion of antidepressants by pharmaceutical companies has widened the boundaries which identify depression, creating a new category of ‘abnormality’. Any changes in the emotional and behavioural functioning which constitute depression, it is argued, are arbitrary. Indeed, prescriptions for antidepressants have tripled in Australia over the past decade, with antidepressants now one of the fastest growing areas in the Pharmaceutical Benefits Scheme. Pharmaceutical companies spend over $7US billion annually on research and development for brain related drugs and the diagnosis of depression is reached within an average of six minutes at a G.P consultation. Human beings, however, are ‘complex, multifactorial and interactive both within themselves and in their transactions with their physical and social environments’. It is argued, therefore, that it is improbable that single-factor models, such as cognition or biology, can ‘capture a good proportion of the variance’ that is depression.
A socio-political analysis of depression will observe that the social landscape of Australia has undergone a dramatic change over recent decades. With 40% of Australian marriages currently ending in divorce, there is now a generation of young people emerging without the critical periods of exposure to secure parenting and attachment to ‘significant others’ which is fundamental to their emotional survival. These family and parental issues are complex and can both precipitate and perpetuate adolescent depression. Depression is pronounced in adolescents from low-income, step or blended and sole-parent families. Although insecure attachment experiences do not exclusively ‘cause’ depression, they can heighten vulnerability to long-term emotional, psychological and behavioural disorders. Any ‘lacking or inconsistent patterns acquired in childhood are likely to transfer to adolescence and then to adulthood’, with consequences for all future relationships and social interactions. It is interesting to observe that societies, such as Spain and Italy, where the divorce rate is low and the extended family system has remained solid, have not experienced high levels of adolescent depression. It has also been suggested that depression is a cultural failing which is more apparent in ‘new’ Western societies, such as Australia and the United States. An estimated 10% of the American population takes antidepressants, while in Australia it is now the fourth most frequently diagnosed condition, with around 700,000 new episodes diagnosed annually. A ‘young’, heterogenous nation with an emerging identity, Australia is without a shared heritage which, it is suggested, could offer a base of permanence and continuity.

The changing nature of the family unit has paralleled the change in broader social cohesiveness in Australia. Social networks have diminished, with the disintegration of communities and a decline of participation in such public sphere structures as churches, sporting, political and recreational associations and social clubs. Such social changes, associated with reduced employment prospects, means adolescents are emerging without ‘two crucial prerequisites’ for positive growth and development, of ‘a close relationship with a dependable adult and the perception of meaningful opportunities in mainstream society’.

An international review of time trends in psychosocial youth disorders found that, in nearly all developed countries since World War Two, there has been a ‘surprising and troubling’ rise in psychosocial youth disorders, including crime, substance misuse,
depression and suicidal ideation and behaviour. Such trends have not been exclusive to marginalised or disadvantaged adolescents. Modern identity is shaped strongly around the ideal of progress and, ‘in a thoroughly depoliticised, capitalist society’ and ‘in the absence of any other reason for being, happiness takes on the character of a religion’, which is ‘promised in everything from new cars to deodorant and holidays … on every billboard, in every television commercial and on endless magazine covers’. Developed countries, with their uneven patterns of wealth distribution, have fostered negative social comparisons. A reappraised economy of needs and wants has intensified expectations which are often disappointed, leading to a sense of hopelessness and disaffection. Disconnected from the wider social apparatus and both ‘disenfranchised and disengaged’, an inadequate framework of hope and morality has weakened both social cohesion and individual resilience. In a mood of diffuse nihilism and pessimism, there is a ‘growing minority’ of adolescents without a solid foundation for a stable adulthood, including ‘questions of relationship to the existing society; questions of vocation; questions of social role and lifestyle’.

Studies have established that, while not ‘negligent or ignorant’ of the challenges to their generation, Australian youths have ‘a pervasive sense of alienation, disillusionment and demoralisation’. ‘Utopian energies’ have been exhausted, with the future negatively cathected in ‘the horrifying panorama of a worldwide threat to universal life interests; the spiral of the arms race, the uncontrolled spread of nuclear weapons, the structural impoverishment of developing countries, problems of environmental overload’.

A national government undertaking targeting youth mental health, MindMatters has been administered by the Commonwealth Department of Health since 2002. Recognising the complexity and interdependency of the origins of mental illness, this programme is conceptually based on the World Health Organisation model of ‘whole-school’ mental health, with its overlapping spheres of mental health education, prevention and protection. Primary health initiatives can be selective, indicated or universal. Selective programs are directed towards students considered at risk of developing a disorder, while indicated programs target students who have emerging symptoms of a disorder. Universal programs remain deliberately broad in approach, achieving health through a capacity-building framework of prevention, promotion and early intervention. Universal initiatives are comprehensive and ongoing,
Integrating prevention, curative services, recovery, relapse prevention and rehabilitation. The advantages of universal initiatives include reducing further recruitment and psychosocial difficulties, enhancing peer support, reaching a broad range of adolescents with differing vulnerability to psychopathology, reducing the stigma associated with mental illness and promoting positive help-seeking behaviours and coping mechanisms.  

Adolescence is an identity-forming phase of development, a time of cognitive and emotional autonomy from parent and authority figures. It is a stage of physical and social change, school transition, increasingly complicated relationships and developing sexuality. Adolescents also expand their capacity for cognition and abstract thought, with the focus often shifting from egocentric to global and existential issues. Depression here can arise from a negative cognitive triad about ‘oneself, the world, the future’, a process which can foster ‘dysphoria, apathy, withdrawal’. This can also result in ‘distorted information processing styles … overgeneralization, magnification, black and white thinking, selective perception’.  

MindMatters, by encouraging a guided discussion of youth life patterns in such areas as drug and alcohol use, depression, suicide, family or relationship problems, attempts the inclusion of adolescents with a broad range of risk factors in the onset of depression.

MindMatters is a programme administered over a two day period to secondary school students, delivered by teachers who have attended the MindMatters professional development training. It is grounded in the understanding that teacher commitment and a positive school ethos are fundamental to creating a ‘health-promoting’ environment. It is intended that ‘broad population’ mental health is best achieved through specific curriculum guidelines on mental health and a partnership between schools, parents and community support agencies.  

A universal initiative, it aims to achieve multiple health outcomes in the areas of understanding mental illness, community matters, diversity, loss and grief, bullying and harassment, educating for life and resilience. MindMatters takes as its fundamental premise the importance of successful psychosocial adaptation in the face of adversity. It understands resilience as a dynamic process of individual and environmental factors. On an individual level is the need for solid social skills and positive cognitive orientation. There is also the
need for a supportive environment and the social connectedness which protects against a poor self-concept. By emphasising the impact of psychological functioning on learning and behaviour, MindMatters can augment existing knowledge in mental health issues, prevalence, myths and treatments.

According to World Health Organisation research, between 20-30% of Australian adolescents require additional support for mental health issues, only a quarter of whom receive it. This has been associated with the relatively poor mental-health literacy of adolescents, which is defined as ‘knowledge or beliefs about mental disorders which aid their recognition, management or prevention’. Poor mental health literacy also contributes to the stigmatisation of mental illness, discourages treatment and can reinforce the behaviours and environments which perpetuate such disorders. This pattern of poor population coverage, and the consequent delay in delivery of effective care, means less than 10% of the health burden arising from depression is currently averted and that around 3.7%, or 138,000, Australian children and adolescents currently suffer depression. As has been previously established in this paper, adolescence is a phase early in the developmental pathway of mental illnesses such as depression, in which adolescents can have complex needs. Known as the ‘window of opportunity’, it is estimated that up to 60% of cases of alcohol or substance misuse could be prevented by the earlier treatment of depression. A cross-systems initiative, encouraging networks with external agencies, it is intended that MindMatters will assist staff in identifying avenues and pathways of care for students with multiple problem behaviours and high support needs.

A national evaluation established that 70% of Australian secondary schools have participated in MindMatters. As a programme, MindMatters is still in its infancy, so it is difficult to estimate its sustained effectiveness. However, to date, positive outcomes associated with MindMatters included improved attitudes, values and knowledge of mental health; improved life-skills and cognitive orientation; improved access to mental-health resources and a higher incidence of mental-health programmes in schools. MindMatters has, however, experienced several barriers in its implementation. Some schools have found it difficult to balance the whole-school and targeted elements of MindMatters, while staff have also expressed reluctance to assume responsibility for the psychological welfare of students. It has been
marginalised by competing curriculum concerns, a limited time-frame and insufficient resources for staff.

The argument has also been made that, with its relatively brief duration, MindMatters is inadequate in altering the developmental pathways of adolescents at risk of chronic or recurring psychopathology. A strong criticism has been that MindMatters has focused on the remediation of deficits based within adolescents, such as negative cognitive style and MindMatters cannot address the public dimensions of wellbeing, nor influence the forces in society which cause such problems as depression. It could be considered counterproductive to attempt to influence a change in human behaviour without achieving a concurrent change in the human environment. Another concern has been that MindMatters emphasises the tension between ‘the educators’ core work of providing the most productive environment for all students and the health professionals’ interest in providing treatment for selected young people who are defined as “at-risk”. Known as ‘the prevention paradox’, this is the observation that a measure which brings large benefits to the community offers little to each participating individual. However, this is the core divide between universal and targeted health initiatives and, given the varied origins and manifestations of depression, it would appear this divide would accompany any effort to address this situation.

This paper began with the observation that the Australian experience, in which depression has the highest health, economic and social capital burden of any disease group, parallels broader global trends in depression. The magnitude and impact of youth depression is extensive and has a high-association with the youth suicide rate, substance misuse and other psychotic disorders. There is also an established link between adolescent-onset depression and adult forms of the disorder. The discussion then shifted to the underlying causes of depression, a complex state with multi-causal origins which can be environmental, genetic or evolutionary in nature. It has also been suggested that depression is a ‘manufactured epidemic’, whereby the marketing of anti-depressants by pharmaceutical companies has ‘medicalised’ a legitimate and appropriate human emotion. A socio-political understanding of depression observes that the changing landscape of Australia has seen the decline of community networks, from the traditional family unit to general participation in the public sphere, which
can buffer adversity. This has coincided with a mood of diffuse pessimism in Australian youth culture. There is a pervasive sense that adolescents are both disconnected from the wider socio-economic apparatus and overwhelmed by such apparently insurmountable issues as environmental decline. A critique of MindMatters followed, an Australian initiative focussing on youth mental health, which, although largely universal in nature, also has targeted elements, particularly in the areas of depression and suicide. MindMatters attempts to improve the mental health literacy of both teachers and students and encourages association with community agencies for individuals identified as ‘at-risk’. Although still in its initial stages, and having experienced certain barriers in its implementation, it would appear MindMatters is a sound response to a complicated issue.


2 Hickie, I.B. ‘Reducing the burden of depression: are we making progress in Australia?’. Medical Journal of Australia, 2004; 181 (7), pp1-5.


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