Suicidality and Melancholia in a 17-Year-Old Girl

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The patient, Ms. A, is a 17-year-old girl who was brought to the emergency department by her mother after expressing a desire to kill herself. She also expressed a 1-year history of low mood (worse in the mornings), with associated loss of pleasure, early morning awakening, poor concentration, low energy levels, and feeling sluggish. She reported breaking up with her boyfriend 1 week prior to admission, stating she had ended the relationship. She was not following up with a psychiatrist or counselor and had not been previously admitted to an inpatient psychiatric unit. She had no significant medical history and was not taking any prescription medications. There was no history of substance abuse and she denied any history of physical, sexual, or emotional abuse. Family history was significant for depression in her maternal grandmother.

Because of concern for her safety, she was admitted to the psychiatry inpatient unit. She was started on citaprom 10 mg in the morning, which was increased to 20 mg in the morning after 3 days. She was also started on hydroxyzine 50 mg at bedtime for insomnia.

Ms. A was not very forthcoming with her stressors initially, and she appeared to be minimizing her symptoms and stressors. Specific questions revealed that she had been bullied in school for the past year, following her transfer to a new school. She stated that a group of female students were very mean to her in school, laughing at her and calling her names. They had even gone so far as composing a disparaging rap song about her. However, her issue of most concern was that these girls were regularly posting mean comments about her on Twitter. She stated that this had been going on for about 1 year. The proverbial last straw seemed to be her boyfriend, with whom she had recently broken up with, joining the Twitter tirade.

She informed the hospital team that she did not want anything done about the bullying, even though she found it very stressful. Although she did not say why, it appeared that she was scared of the implications of her schoolmates being called to order on this issue. It was suggested that it may be beneficial for her to stay away from social media sites, as the postings on these sites appeared to be her primary stressor. Her parents were also advised to discuss this bullying incident with the school authorities.

Ms. A’s symptomatology clearly met criteria for a major depressive episode. She also met criteria for the melancholic features specifier, as she had loss of pleasure in almost all activities and a lack of reactivity to usually pleasurable stimuli. There was also a distinct quality to her depressed mood, which tended to be worse in the mornings and was associated with early morning awakening and marked psychomotor retardation. She presented with significant anorexia and had hardly eaten anything in the 2 days prior to presentation.

However, she did not present with significant weight loss or excessive guilt feelings. Her depressive episode was related to the chronic history of “cyber bullying,” which was made worse by her ex-boyfriend in the week prior to admission.

After being admitted to the inpatient unit, a biopsychosocial approach to her management was instituted. This included antidepressant therapy, group and individual psychotherapy, and parental discussions to eliminate ongoing cyber bullying. She continued to improve, and by the fifth day of admission she was devoid of any
depressive symptoms or suicidal ideations. She was discharged from the ward on the fifth day on citalopram 20 mg in the morning and hydroxyzine 50 mg at bedtime. She was seen in the medication management clinic 3 weeks after discharge and was noted to be doing quite well. She had no depressive symptoms or suicidal ideations. She stated that she had deleted her Twitter account, as this had been her biggest stressor.

DISCUSSION
Cyber bullying has variously been referred to as “electronic bullying” and “bullying using technology.” It involves the use of devices such as cell phones, computers, tablets, and game consoles, as well as forms of electronic communication such as text messages, email, chat rooms, websites, and social media sites such as Facebook and Twitter. Unfortunately, this is a growing problem that has yet to receive the attention it deserves. Kowalski and Limber\(^1\) reported that among their sample of 3,767 middle school students in the southwestern and northwestern United States, 22% reported involvement in cyber bullying.

Bullying is a phenomenon found globally, although the reported prevalence rates differ from country to country.\(^2\) It is defined as a specific form of aggression that is intentional, repeated, and involves a disparity of power between the victim and perpetrator.\(^3\) The technological savviness of teenagers, widespread accessibility of devices such as smart phones and computers, as well as the ability to be online without much adult supervision, has contributed to an increase in cyber bullying. It presents in various forms, such as derogatory and threatening text messages and emails, negative Facebook and Twitter messages, derogatory websites, fake Internet profiles, embarrassing YouTube videos, mobile phone pictures, and slander in chat rooms.

Among the numerous deleterious effects of cyber bullying is the fact that children who are bullied electronically have a harder time getting away from this act. It can occur on a daily basis, day and night, and reach targeted individuals even in their private environments. It has the ability to be done anonymously while getting to a very wide audience in just a matter of minutes. The consequences of bullying include depression, anxiety, psychosomatic symptoms, social ineffectiveness, interpersonal difficulties, school absenteeism, and lower academic competence.\(^4\) A meta-analytic review of cross-sectional associations between peer victimization and psychosocial maladjustment provided clear evidence that peer victimization is most strongly related to symptoms of depression and least strongly to anxiety.\(^5\) Qualitative data suggest that in comparison with traditional bullying forms, cyber bullying evoked stronger negative feelings, fear, and a clear sense of helplessness.\(^6\) This makes it more likely that being a victim of cyber bullying might be even more strongly associated with depressive symptoms than traditional victimization.\(^7\) Rapid changes in technology as well as the metamorphosis of cyber bullying techniques has made it relatively difficult to design proper studies to accurately capture trends.

CONCLUSION
Cyber bullying is becoming increasingly rampant in our teenage population, carrying with it dire consequences such as hospitalizations and even suicides. Unfortunately, many victims (as was the case in our patient) are not willing to talk about it openly. This may be due to several reasons, including fear of threats from the bullies. This makes it important for the physician to ask direct questions about bullying. Our patient improved and remains stable, and every effort was made to directly ascertain the possibility of bullying and follow through to ensure it is terminated. It is important to increase awareness of cyber bullying among mental health professionals as well as school staff and parents. In addition to making it known to students that there are hotlines available to discuss problems with bullies, they should continually be educated on this important subject. Furthermore, it would be helpful for clinicians if more surveys and studies were carried out on this matter.

REFERENCES