

DEPRESSION IN CHILDREN & ADOLESCENTS: REVIEW

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ABSTRACT: Depression is treatable but depressed children and adolescents may present a different behavior than those of depressed adults. Hence, child and adolescent psychiatrists caution parents to be acquainted with the signs of depression in their children. Adolescent depression is associated with a range of adverse later outcomes including suicidality, problems in social functioning and poor physical and mental health. Across development, a family history of depression and exposure to stressful life events are the most robust risk factors for depression. The diagnostic criteria for depression in children and adolescents and for adults are basically the same, but the expression of symptoms varies with each developmental stage (Bhatia & Bhatia 2007, 73). Because of the related developmental issues, diagnosing depression on these age groups is deemed difficult (Rutter 1995; Cicchetti et al. 1998; Crowe et al. 2006, 11). In some cases, children and adolescents have difficulties in identifying and describing their internal mood states (Bhatia & Bhatia 2007, 73).

KEYWORDS: Depression, Adolescence, Childrens.

Depression imposes itself not only on adults but it takes its toll on children and adolescents as well. Normally, parents want their children to be happy. Yet despite doing their best to provide and protect them, children may still encounter disappointments, frustrations, or real heartbreak. At times, children may feel sad and needy. However, some children and adolescents seem to be constantly experiencing sorrow, hopelessness, and helplessness. Depression is an illness where the feelings of depression persist and intervene with the child or adolescent functional ability. (AACAP 2008). The characteristic of a child and adolescent depression is not always manifested by sadness but by irritability, boredom, or an inability to feel pleasure. Depression is a chronic, recurrent, and mostly an inherited illness. Frequently, the first appearance of depression occurs during childhood or adolescence. Prolonged depressive episodes happen in an individual with dysthymic disorder (a milder depression that is constituted by an insidious onset and chronic course) that gradually progresses into major depression. Depression in adolescents is a disabling condition that is associated with serious long term morbidities and even suicide (William et al. 2009, 716). About five percent of the general population of children and adolescents may experience depression at any given point in time (AACAP 2008, www.aacap.org) and its prevalence continued to rise (William et al. 2009, 716). Although depression is common among children and adolescents, it is still frequently unrecognized or undetected (Son & Kirchner 2000, 2297).

A child diagnosed with depression has an increased risk of developing depression in his or her adulthood (Murphy 2004, 19). However, although there were substantial evidences in the continuity of depression from adolescence to adulthood, the consistency in the result in the continuity from pre-pubertal to adulthood is less (Carlson & Kashani 1988; Klein et al. 2005, 413). Follow-up studies in the group of pre-pubertal children generated varying results. In some studies, the results indicated that depressed children are at high risk of developing depression in adulthood while other results did not indicate evidence of increased risk except for other particular subgroups. (Harrington et al. 1990; Weissman et al. 1999; Klein et al. 2005, 413-414.)

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Age dependent psychopathological symptoms of depression (MehlerWex & Kölch 2008, 150).

Age Group	Psychopathological Symptoms
Toddlers	Restlessness, screaming; Unprompted crying attacks, irritability, agitation; Disinterestedness, passivity, apathy, lack of expression; Reduced creativity, imagination and stamina Clinginess, silliness; Auto stimulating behavior
Preschool Children	Crying, irritability, aggressive and explosive outbreaks, Hypomimia, reduced gestural activity/passive general motor response, introversion, lack of interest; Joylessness, attention seeking behavior; Low frustration tolerance, aggressiveness Delayed social and cognitive developments
School Children	Crying, defiant behavior, defense, aggressive behaviors; Self-reported sadness, listlessness and lack of drive, Disinterestedness, withdrawal; Problems concentrating, failure at school Worries, initial thoughts expressing tiredness of life; Attention seeking
Adolescents	Apathy, despair, refusal, lack of drive, disinterestedness, withdrawal; Thoughts and actions slowed down, problems in performance/achievements, cognitive impairments; Anxiety, disgust, lack of self-confidence, self reproachfulness, brooding, fear of the future, suicidality

Adolescence is a critical time of development and it signifies a period of high risk for depression. At this stage of development, depressive symptoms are often dismissed or ignored as signs of adolescence or teenage behaviours. Any abnormal or unusual behaviour shown by them are often linked to the „temporary phase“ that they are going through or occasional bad mood rather than suffering from depression. Depressed mood has been referred as a common experience during adolescence. (Steinberg 1999, Gil-Rivas et al. 2003, 93.)

The pre-pubertal age depression rate for boys and girls are similar, and doubled in females after puberty (Dopheide 2006, 234). Females are at a higher risk of first onset of major depression from early adolescence until their mid-50's and have a lifetime depression rate of 1.7 to 2.7 fold greater than males. Studies reported that girls are more depressed and more severely depressed than boys. (Crowe et al. 2006, 12.)

Age dependent somatic symptoms of depression (Mehler-Wex & Kölch 2008, 150)

Age Group	Somatic Symptoms
Toddlers	Disruptions to falling asleep/sleeping through because of insufficient self-calming strategies Eating disorders and refusal to eat accompanies by weight loss, increased proneness to infections
Preschool children	Regressive use of language; Delays in motor development Sleeping and eating disorders Secondary enuresis and encopresis
Schoolchildren	Sleeping and eating disorders Somatic complaints; Regressive behavior
Adolescents	Sleeping and eating disorders Psychosomatic complaints Low morning mood; Early waking; Inability to relax and rest

According to Crowe et al. (2006, 13), there are some gender differences in the clinical presentation of depressive symptoms. In a Swedish high school study, the most common symptoms for the boys were sadness, crying and suicidal ideation. While symptoms such as, fear of failure, self-dislike, feeling unattractive, guilt, and suicidal ideation were found in girls. (Olsson and Von Knorring 1997; Crowe et al. 2006, 13). Additional study by Marcotte et al. (1999); Crowe et al. (2006, 11) reported a higher frequency of helplessness, fear of abandonment and internalization with girls and externalizing behaviours and self-criticism with boys.

Moreover, Crowe et al. (2006, 15) also confirmed that depressed girls are more likely to have internal symptoms such as feeling lonely and unhappy, crying and hating themselves. The study also concluded that for both the adolescent girls and boys, the most common reported characteristics of depression includes interpersonal (social withdrawal, irritability and loneliness) and thought processing symptoms (concentration and indecisiveness).

The risk for depression may also increase by two- to threefold in the presence of comorbidities such as substance abuse and anxiety disorders (Dopheide 2006, 235). Other common comorbid conditions involve attention-deficit /hyperactivity disorder (ADHD), post traumatic stress disorder (PTSD), oppositional defiant disorder (ODD) and trauma –related hallucination (Costello et al. 2003; Saluja et al. 2004; Dopheide 2006, 235). Moreover, certain reproductive-related hormonal change may play a role in placing females at an increased risk of depression. Thus the prevalence of depression rises gradually with age and pubertal development. (Stein 2002; Crowe et al. 2006, 12).

Mehler-Wex and Kölch (2008, 151) affirmed that the pre-morbid risk factors in 70% of depressed children and adolescents were found to be the critical life events. Furthermore, chronic stresses such as problems in social relationships, a lack of friendship and attention, subjective experiences of low attractiveness, etc., can also play a role in triggering depression (Eley et al. 2000; Mehler-Wex & Kölch 2008, 151). Children and adolescents with depression are found to be more likely to report having experienced negative life events than those without depression. While some of these negative events triggered the onset of depression, other events like loss of friendship or family conflicts may be caused by depression itself. (Richardson & Katsenellenbogen 2005, 9.)

Depression in children and adolescents involves developmental process associated with difficulties in concentration and motivation. This then, leads to poor academic performance, impaired social functioning, poor self-esteem and a higher risk of suicide. Even after recovery from depression, young people may still be at greater risk of experiencing psychosocial difficulties such as a reduced capacity for intimacy, loss of social supports and increased use of alcohol and drugs. (Crowe et al. 2006, 11.)

CONCLUSION & DISCUSSION

Most treatments for youth depression were first developed in the treatment of adults, and were later used with young people. In contrast to the developmental focus of much epidemiological and neurobiological research into depression, treatment studies have so far rarely directly examined whether developmental factors have predictive or moderate effects on treatment outcomes. In part this may reflect practical difficulties of conducting clinical studies with large enough sample sizes to allow robust comparisons across developmental periods. Treatment of preschoolers with depression is currently being evaluated (Lubi, 2010). We focus here on three main evidence-based treatments for depression in older children and adolescents: pharmacotherapy with fluoxetine or other serotonin reuptake inhibitors (SRIs); Cognitive and Behavioral Therapy (CBT); and, Interpersonal Therapy (IPT). Most of the current evidence relates to the short-term effects of these treatments as measured in randomized control trials (RCTs); Little is known about their effect on long-term outcomes at this stage. Family involvement in the treatment of depression is very important, especially in the case of children and adolescents. Parents should know that recovery from depression is possible but treatments require their commitments. The road to recovery is gradual and it may take time. Families should be educated that depression is common during this age group and it is a common mental illness and not a character defect or weakness. It is also helpful if parents discuss the symptoms with their children because depression is not just in the mind, it also affects the body, behavior and their thinking. (Richardson & Katsenellenbogen 2005, 15.) Depressed people often spend more time brooding about their symptoms or sleep and withdraw from the activities they used to enjoy. Physical activities are encouraged because it may help decrease depressive symptoms. It can begin by walking each day or joining in some kind of sport. Parents are advised to engage in activities that can help change the negative thoughts of their children. For example, they can help younger children increase their activities by organizing family outings, or go for a walk, bicycle rides, or trips to places that children might enjoy. (Dwight-Johnson et al. 2001; Richardson & Katsenellenbogen 2005, 16.) The general core objectives of depression therapy according to Mehler-Wex & Kölch (2008, 153) are: to reduce stress factors, to increase positive activities, to impose a structure on daily life, to promote and raise awareness of the available resources, to train in social competences, to learn solving problem strategies, to modify the negative patterns of perception and interpretation, and to increase self confidence and self esteem. With efficacy rate of 60-70%, the first-line treatment for depressed children and adolescents is CBT (Dopheide 2006, 237). CBT is one of the widely used psychotherapeutic techniques which focus on changing negative self-defeating thought patterns, increasing positive behaviors and activities, and improving interpersonal effectiveness (Richardson and Katzenellenbogen 2005, 20).

- Make sure that your child understands what you are saying and is not confused or bored by the discussion.
- Use words that your child can understand. Words such as "depression" or "emotional reaction" are probably too complex for a younger child but may be appropriate for an older child or adolescent.
- Try comparing your child's depression to something that your child is already familiar with like a physical illness such as the flu or an ear infection.
- Depression is a serious illness that causes emotional and physical pain, but try to keep the conversation focused on the positive.

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