M.I.N.D

Depression in Children and Adolescents

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Disorder name

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Introduction

Major depression is an episodic, recurring disorder characterized by persistent and pervasive sadness or unhappiness, loss of enjoyment of everyday activities, irritability, and associated symptoms such as negative thinking, lack of energy, difficulty concentrating, and appetite and sleep disturbances. Manifestations can vary according to age, gender, educational and cultural background. The various subtypes of depression are identified on the basis of symptom severity, pervasiveness, functional impairment, or the presence or absence of manic episodes or psychotic phenomena.

Overview and facts

Most studies concur that about 1% to 2% of pre-pubertal children and about 5% of adolescents suffer from clinically significant depression at any one time. For example, by the age of 16 years 12% of girls and 7% of boys would have had a depressive disorder at some time in their lives. Prevalence of dysthymic disorder is less well known but studies suggest a point prevalence ranging from 1% to 2% in children and 2% to 8% in adolescents. A further 5% to 10% of young persons have been estimated to exhibit sub-syndromal depression (or minor depression). Youth with minor depression show some functional impairment, increased risk of suicide and of developing major depression.

Gender and culture

The ratio of depression in males and females is similar in pre-pubertal children but becomes about twice as common among females compared with males during adolescence.

Symptoms

Depressed patients can display symptoms of depression at any age; however, the pattern varies slightly according to developmental stage, resulting in differences in the way depression manifests itself through the lifespan.

Age at onset does not seem to define separate depressive subgroups, but earlier onset is associated with a greater possibility of conversion to Bipolar Disorder, as well as with multiple indicators of greater illness burden in adulthood across a wide range of domains such as never being married, more impaired social and occupational functioning, poorer quality of life, greater medical and psychiatric comorbidity, more lifetime depressive episodes and suicide attempts, and greater symptom severity.

Although to diagnose clinical depression it is required that symptoms be present every day, most of the day for at least two weeks, adolescents, particularly those who suffer from mild or moderate depression, often have a reactive affect and can, with effort, hide their symptoms.

Course

Similar to what happens in adults, clinical depression in youth follows a recurring course. An episode of depression in clinically referred patients lasts 7 to 9 months on average, but it can

be shorter in non-referred community samples. That is, depressive episodes are, on average, a spontaneously remitting illness.
Conversely, there is a 40% probability of recurrence within 2 years. Recurrenceis high even after treatment.
The likelihood of further episodes in adulthood is up to 60%. Thus, depressive illness should optimally be conceptualized as a chronic condition with remissions and recurrences. This has important implications for management, which should seek not only to reduce the duration of the depressive episode and lessen its consequences but also to prevent recurrences. Predictors of recurrence include poorer response to treatment, greater severity, chronicity, previous episodes, comorbidity, hopelessness, negative cognitive style, family problems, low socioeconomic status, and exposure to abuse or family conflict.

Causes and risk factors

The etiology of depression is complex, multifactorial and the object of much academic argument. Research has uncovered a multitude of factors associated with the onset, maintenance or recurrence of depression.
In summary, depression in youth appears to be the result of complex interactions between biological vulnerabilities and environmental influences. Biological vulnerabilities may result from children's genetic endowment and from prenatal factors. Environmental influences include children's family relationships, cognitive style, stressful life events, school and neighborhood characteristics. Parental depression is the most consistently replicated risk factor for depression in the offspring. Stressful life events—especially losses—may increase the risk for depression; this risk is higher if children process loss events (or other stressful life events) using negative attributions. Parental lack of care and rejection may also be relevant.
Comorbidity, the simultaneous occurrence of two or more distinct illnesses in the one individual, is a common and complex issue across all child and adolescent mental disorders that has great theoretical and practical implications—for example for treatment—and is still not resolved satisfactorily.Psychiatric disorders often comorbid with depression include anxiety disorders, conduct problems, attention deficit hyperactivity disorder (ADHD), obsessive compulsive disorder, and learning difficulties.

Depression and suicidal behavior

Suicide is one of the leading causes of death in adolescents worldwide. For each completed suicide in adolescents, there are about 100 reported suicide attempts. Suicidal thoughts are common among the young; about one in six girls aged 12 to 16 reports having them in the previous six months (one in ten for boys) but rates in clinic samples are much higher. While suicide is the result of complex interactions in which individual and psychosocial factors as well as mental health problems play a role, there is considerable evidence that depression is the strongest individual risk factor.
About 60% of depressed young people report having thought about suicide and 30% actually attempt suicide. The risk increases if:
• There have been suicides in the family
• The young person has attempted suicide previously
• There are other comorbid psychiatric disorders (e.g., substance abuse), impulsivity, and aggression
• They have access to lethal means (e.g., firearms)
• They have experienced negative events (e.g., disciplinary crises, physical or sexual abuse), among others.
Suicidal behaviors and risk need to be carefully evaluated in every depressed young person.

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Tests and diagnosis

While diagnosis is not usually difficult, depression in children and adolescents is often not detected or treated. Young people tend to present initially with behavioral or physical complaints which may obscure the typical depressive symptoms seen in adults. Complaints which should alert clinicians to the possibility of depression include:

- Irritability or cranky mood.
- Chronic boredom or loss of interest in leisure activities (for example, dropping out of sporting activities, or dance and music lessons).
- Social withdrawal or no longer wanting to "hang out" with friends.
- Avoiding school
- Decline in academic performance.
- Change in sleep-wake pattern (for example, sleeping in and refusing to go to school).
- Frequent unexplained complaints of feeling sick, headaches, stomachaches.
- Development of conduct problems (such as becoming more defiant, running away from home, bullying others).
- Abusing alcohol and other substances.

ADHD and disruptive behavior disorders

Irritability and demoralization are very common symptoms in children— particularly pre-pubertal children—who suffer from ADHD, oppositional defiant disorder or conduct problems, often in a context of significant family dysfunction, poverty, neglect, foster care or institutionalization. In these cases it is difficult to establish whether demoralization is the result of the child's plight or a manifestation of clinical depression. If symptoms meet criteria for depression, a comorbid diagnosis of depression (i.e., two diagnoses) is encouraged by the DSM system.

Treatment

It is necessary to aim high, that is, to achieve full remission of symptoms and a return to the premorbid level of functioning (recovery). Anything less is a suboptimal outcome because persistence of depressive symptoms increases the likelihood of poorer psychosocial functioning, suicide and other problems.

Psychosocial interventions

Psychosocial interventions in particular cognitive behavior therapy (CBT) and interpersonal psychotherapy (IPT) appear to be effective in the treatment of mild to moderate depression. The optimal number of CBT and IPT sessions is not known. Most studies report using weekly one-hour sessions for 8 to 16 weeks, though booster sessions may improve outcomes and reduce recurrence. In practice the number of sessions can be tailored to patients' needs, severity of the illness and other relevant factors.

Medication

Antidepressants are an important weapon for treating depression in the young, however several antidepressants that are effective in adults are not effective in youth or too risky to use in this age group highlighting the issue that empirical data obtained in adult treatment trials cannot necessarily be generalized to children and adolescents.

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A key aspect of prescribing and of obtaining informed consent is to discuss with the patient, and family if appropriate, the reasons for the medication, the possible adverse effects (including emergence or escalation of suicidal thinking, nervousness, agitation, irritability, and mood instability), the need to take medication as prescribed, and the delayed action of antidepressants (to dampen expectations of immediate benefit). Good practice also recommends reviewing the patient at weekly intervals for the first month once medication is prescribed. These reviews allow further supportive management and monitoring of side effects and response.

Under-treatment—not enough medication or not for long enough—is a common error in clinical practice. Although it is important to start with a low dose, the amount of medication should be gradually increased until symptoms lessen or side effects appear, keeping in mind that there is wide individual variation.

Sources and Links

http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/Facts_for_Families_Keyword.aspx

http://www.depressedchild.org/