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Childhood Depression

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It has only been within the past two decades that the majority of clinicians and researchers reached agreement that children can experience a depressive disorder. Initially, researchers believed children's lack of psychosexual development prohibited development of depression in childhood.

There has also been disagreement regarding which symptomatology comprises childhood depression, and how it differs from depression in adults. Many clinicians and researchers shared the belief that depression in children was "masked" by other symptoms (e.g., aggression, enuresis, anxiety, among others). More recent research has identified and emphasized the similarities between depressive symptoms experienced by adults and children. Cohort data suggest that the age-of-onset of depression has decreased, and prevalence has increased as compared to children born in the first half of the 20th century.

Prevalence

While depression does occur in childhood, it is more likely to manifest in adolescence and adulthood. Estimates vary, but it appears that between 0.3-2.5% of prepubertal children may be diagnosed with Major Depressive Disorder, and between 0.6-2.5% with Dysthymic Disorder Depression in preschoolers is less common than in older children, and is typically associated with instances of extreme abuse and neglect. Depression is equally present in both males and females in childhood, however, a gender difference does appear after onset of puberty, with more females reporting depressive disorders than males.

Assessment

Childhood depression can be assessed via several different strategies. Self-report scales, semi-structured clinical interviews, peer report or nomination, parent/teacher/caregiver rating scales, behavioral observation, and biological and/or psychophysiological measures have all been utilized to assess depression in young children. The most commonly used methods of assessment are self-report and parent/teacher/caregiver rating scales. An obvious difficulty affecting both diagnosis and treatment of depression is that young children often prove to be poor informants of their feelings, and in particular, have difficulty identifying the temporal and causal relationships between their moods and events.

Course

A Major Depressive Episode is a period lasting a minimum of two weeks consisting of either depressed mood or anhedonia. In children and adolescents, the mood may be irritable rather than sad. A Major Depressive Disorder is a clinical course characterized by one or more major depressive episodes, without history of manic, mixed or hypomanic episodes. Dysthymic mood is described as a generally "low" mood, infrequently experiencing joy or excitement. Those experiencing dysthymic mood are often described as feeling "down in the dumps." Dysthymic Disorder is comprised of a chronically depressed mood that occurs most of the day (more days than not) for at least two years. For children, the duration only needs to be one year, and their mood may be irritable rather than sad or depressed. The initial one to two years (depending on age) of the Dysthymic Disorder must be free from a Major Depressive Disorder.

The course of a major depressive episode and dysthymia in children present differently than in adults. A major depressive episode typically lasts for 32-36 weeks in children or adults, and has a maximal recovery rate of 92%. Recovery for a major depressive episode is relatively protracted, with the greatest improvement in reduction of depressive symptomatology occurring between the 24th and 36th week. The average length of Dysthymic Disorder is much longer than a major depressive episode, at 3 years. The younger the child is at onset, the more likely they are to experience a relapse, and are more likely to have recurrent episodes of depression as adults.

Comorbidity

It is well established that children who are depressed often experience additional psychological disorders. Anxiety is the most commonly diagnosed comorbid disorder with depression in children, with 25-50% of depressed youth also diagnosed with an anxiety disorder. On average, children who experience comorbid psychological disorders report more severe impairment and often suffer more long-term consequences.

Criteria

The Diagnostic and Statistical Manual of Mental Disorders: Text Revision (DSM-IV TR) outlines the criteria for the different mood disorders. Diagnostically, there is little difference in adult and child criteria

for a diagnosis of depression with the exception that the duration of dysthmia is 1 year for children instead of 2 years, and "irritability" can be considered a manifestation of dysphoric mood. The DSM-IV TR criteria for a major depressive disorder requires persistent depressed (or irritable) mood or a marked decrease in interest or pleasure in most or all daily activities for at least two weeks. In addition, four of the following features must be present during the same two week period: weight loss or gain, sleep disturbance, psychomotor agitation or retardation, fatigue, feelings of worthlessness or guilt, reduced concentration, or recurrent thoughts of death. Symptoms must lead to significant distress or impairment of functioning and must not be due to substance misuse, physical illness, or bereavement.

Etiology-Familial Environment/Genetics

Familial and environmental factors play a large role in the development of depression in young people. High parental criticism, parental discord, and poor parent-child communication has been associated with onset and course of depression in youth. Both depressive symptoms and disorders have been significantly associated with undesirable life events.

Parental psychopathology also appears to be a significant risk factor for both the development and the course of childhood depression. Forty-five percent of children with mothers diagnosed with depression met criteria for a major depressive disorder, compared to 11% of children who were diagnosed as depressed whose mothers were not depressed. A longitudinal study of depressed children whose parent(s) were also depressed found more severe episodes of depression in a ten-year follow-up than children without depressed parents.

Experiencing single risk factors (e.g., prepubertal onset, familial history of depression, parental psychopathology, stressful life events, and low family support) appears to be associated with an increase in being diagnosed with childhood depression. However, when these risk factors are experienced in combination, the likelihood of impairment in the child is greater. Many researchers have found that an increased number of risk factors is associated with increased impairment.

Risk factors, such as the diathesis-stress model that has been validated in studies of adult depression have also been validated for childhood depression. Children who have a general negative cognitive style (irrespective to the onset of a stressor) report higher levels of depression after a stressor in comparison to children who do not endorse a negative cognitive style. It is important to note that due to developmental considerations, few studies have examined the relationship between cognitive style and depression in children under the age of eight.

Etiology-Biological

There also appears to be a biological component for depression in children. Research has found that depressed children hyposecrete growth hormones in comparison to non-depressed peers, even after the depressive episode has subsided. Biological disregulation among depressed children is found in their neurochemistry, specifically identifying serotonin, neorpinephrine and acetylcholine as contributing to mood disorders.

When a child is depressed, it is likely due to a combination of genetic vulnerability and exposure to severe trauma or stressors. Thus, the manifestation of childhood depression appears to be a mix of both "nature" and "nurture."

Prevention

School based prevention programs involving preadolescents at risk for depression found that students participating in either a school based cognitive training program, social problem-solving program, or com-

bined cognitive and social problem-solving program reported significantly fewer depressive symptoms than a control group.

Treatment

Treatment for childhood depression has significantly lagged behind treatment for adults. It is only in the past 10-15 years that studies have been conducted testing the efficacy of psychopharmacological and therapeutic treatments.

Pharmacotherapy

The use of serotonin reuptake inhibitors (SSRIs) appears to be somewhat effective in treating childhood depression. A recent study found that 56% of patients 7-17 years old receiving the SSRI fluoxetine demonstrated clinical improvement compared to 33% receiving placebo. Tricyclic antidepressants, which are frequently prescribed for treatment of depressed adults, have received mixed conclusions when used with children. This lessened success with children may stem from the developmental changes occurring in the neurotransmitter system.

Psychotherapy

Cognitive Behavioral Treatment: Individual cogmtlve behavioral interventions have proven effective in reduction of depressive symptomatology; lessening duration of depressive episodes, and in facilitating remission of a depressive episode in children and adolescents. Cognitive behavioral treatment typically includes pleasant events activity scheduling, self-control skills, problem solving, and cognitive restructuring. Treatment can be time limited, often between 10-12 sessions, over a five to 12 week duration.

Behavioral Treatment: Many behaviorists believe depression occurs from a lack of reinforcement in the environment. If a child does not receive reinforcement (e.g., praise, interactions, touch), depressive symptoms may occur. Reinstatement of reinforcement in the environment will likely result in reduction of depressive symptomatology. Little research regarding this type of treatment has been conducted with children; however, research has found that increasing social reinforcers is an effective treatment with depressed adults.

See also: Anxiety; Child abuse; Childhood; Cognitive Behavioral Therapy (CBT); Depression

Suggested Reading

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