

Depression in Children: The Why and Wherefore's

ABSTRACT: *Depression in children has long been an overlooked health problem. While it is fairly well known to the general public that clinical depression is common (sometimes referred to as "the common cold of mental illness"), affecting 10 to 15 % of the adult population at some point in life, it is not commonly known that depression in childhood is also a major health problem.*



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In fact, depression in children is arguably a more significant issue than is adult depression. For example, about 5% of children at any given time suffer from clinical depression; this naturally occurs during critical phases in child development, and not only can show itself with behaviors and feelings not commonly viewed as part of a "depression," but can interfere with the normal developmental processes of childhood.

Depression in children can, if untreated, affect school performance and learning, social interactions and development of normal peer relationships, self-esteem and life skill acquisition, parent-child relations and a child's sense of bonding and trust, can lead to substance abuse, disruptive behaviors, violence and aggression, legal troubles and even suicide.

According to one study, suicide is the 3rd leading cause of death among children and adolescents, just behind accidents and violence.

Moreover, depressive thinking can become part of a child's developing personality, leaving long-term effects in place for the rest of a child's life.

Childhood depression is a serious problem that demands a serious treatment and approach. However, one obstacle to eliminating depression in chil-

dren is first to recognize it for what it is. Often children's behavioral problems are only brought to professional attention when they are obvious: they may cause classroom disruption, expulsion from school, school failure, or injury to themselves or others. These behaviors may be seen as symptoms of ADHD, Oppositional Defiant Disorder, "truancy," "delinquency," or other vague problems and never recognized to be manifestations of an underlying depressive disorder. It is important to determine if depression is a part of the overall behavioral picture, because many effective therapies and interventions are available today.

WHAT TO LOOK FOR IN CHILDREN?

Depression is a disorder that is defined by certain behaviors and thought patterns. Although the core troubles are the same for children as they are for adults, often the specific behaviors are different and vary according to the age and developmental level of the child. Importantly, often a child or adolescent is unable to say that they are "depressed" or "sad." Rather, they may say that they are bored, angry or are just not happy. As examples of how depressive behavior can be somewhat different in adults versus children, below is a list comparing the major symptoms of depression.

ADULT SYMPTOM	CHILD EXAMPLE	ADOLESCENT EXAMPLE
Depressed/sad mood	Irritable, argumentative, aggressive, whining/crying	Argumentative, aggressive, emotionally sensitive
Diminished interest/pleasure,	Not as motivated or playful, not	Isolative, quits activities, shows

inability to feel pleasure	as curious and explorative, school work drops off, boredom	no initiative, grades drop, boredom
Unintentional weight changes Sleep changes	Fails to gain weight normally Difficulty falling asleep or staying asleep	Weight changes Difficulty falling asleep or staying asleep, stays up all night
Being slowed down or sped up	Difficulty concentrating or sitting still, impulsivity, less active or interactive, hyperactive, disorganized	Difficulty concentrating or sitting still, impulsivity, less active or interactive, disorganized
Fatigue	Needs rests, naps, complains when is pushed to do things, plays "sick"	Refuses to participate, lays around a lot, sleeps during day, acts "sick" a lot
Worthlessness and guilt	Makes negative self-comments such as "You hate me" and "I'm stupid"	Makes negative self comments such as "I'm fat" "I'm ugly" "Everybody hates me"
Poor concentration, can't make decisions	Poor attention and concentration, easily distractible, disorganized	Poor attention and concentration, easily distractible
Thoughts of death or suicide	Talks about death, states "I wish I was never born" or "I wish I was dead"	Obsesses on death and morbid topics, voices wishes to be dead or thinks about/attempts suicide
Psychosis: hearing things, seeing things, or paranoia	Extreme fears for safety, seeing scary images, hearing monsters	Suspiciousness, paranoia, seeing fearful images or hearing their name called

These problems must lead to significant difficulties in peer interaction, play and recreation, school performance, family interactions, or disturbance of normal development. They must last at least 2 weeks continually, must not be the result of drug or alcohol use, and not be due to bereavement or grief after a loss.

As seen in clinical practice and in some studies, the most common symptoms of depression reported in children and adolescents were sadness, inability to feel pleasure, irritability, fatigue, insomnia, lack of self-esteem, and social withdrawal.

Children are as well somewhat more likely than adolescents to suffer from physical symptoms (eg, stomach aches and headaches), hallucinations, agitation, and extreme fears. On the other hand, adolescents showed more despairing thoughts,

weight changes and excessive daytime sleepiness.

HOW COMMON IS DEPRESSION?

As stated above, in general about 5% of children and adolescents nationally could be diagnosed with depression at any given time.

Further studies have shown that this number changes as children age: about 1% of preschoolers, 2% of school-age children and 5% of adolescents are affected. About 25 to 50% of all children and adolescents in psychiatric treatment are seen for depression and its related problems.

Childhood depression appears to be more common in boys than in girls (about a 5 to 1 ratio, boys to girls) until adolescence, when it becomes more common for girls than boys (2 to 1 ratio, girls to boys).



Children who have biologic relatives that suffer from depression, anxiety disorders, and substance abuse disorders have a biologic tendency towards depression and are more likely to develop clinical depression than children that do not have biologic relatives with these disorders.

RISK FACTORS: WHAT ELSE TO LOOK FOR?

Unfortunately depression in children and adolescents does not always show up alone: frequently there are one or more problems associated with the depression, making it important for the doctor to discover and treat. If not, the undiscovered and untreated problems will likely interfere with the depression treatment and complicate the picture. Frequent illnesses that accompany depression include anxiety, phobias, obsessive compulsive disorder, ADHD, substance abuse, oppositional defiant disorder, learning disorders, and delinquent behaviors.

WILL THE DEPRESSION COME BACK AGAIN?

For the majority of children, the answer is **Yes**. However, it is not known when depression may recur or how severely. Depression that remains untreated on average may last 9 months and take 9 more months to fully resolve. With treatment, the length of the depressive episode is much shorter, and the child will recover more quickly. This results in less disruption to the child's life and quicker return to normal function at home, with friends and family, at school, and in the normal course of development. It is believed that treatment of depression as well can serve to reduce the likelihood of depression recurring; or if depression does return, treatment delays the return of symptoms and reduces the severity of symptoms overall. From a statistical point of view, about 70% of children and adolescents will have another episode of depression within 5 years of the first one. Fortunately, if the child and his family sought treatment the first time, they are very educated about depression and its signs, and so can be on the lookout for the earliest; most subtle changes associated with a returning depression and can immediately seek help and early treatment.

WHAT CAN BE DONE?

Successful treatment of childhood and adolescent depression has proven to require interventions on several strategic fronts:

- Thorough and accurate **diagnostic evaluation** of the child. As depression in childhood is commonly confounded by multiple disorders, it is vital to the treatments success that all disorders be discovered and addressed. Many of these disorders can be helped with appropriate use of **medications**. Also, **individual therapy** is often beneficial for the patient, and can specifically help with issues of family conflict, self-esteem, relaxation strategies, mood and anger control, and better communication.
- Evaluation of the **school environment** and its impact on the current situation. Very frequently school and peer issues can lead to and/or perpetuate an environment in which the child's depression can take root and grow. It is important, therefore, that assessment of the school be done so that modifications to the demands placed on the child may be appropriately completed so as to best create an environment that fosters recovery while not unduly affecting the educational process. This usually involves the interaction of the school counselor, principal, psychologist, teachers, and parents. Some interventions include psycho educational testing, speech and occupational therapy, in-school counseling, curriculum modification, resource classes, behavioral modification systems, ARD meetings, self-contained classrooms and alternative placements.
- Evaluation of the **home/parental environment** and its impact on the current situation. Home life can also contribute to the development and/or continuance of a child's or adolescent's depression. Like school modification and intervention, family and home modification may be necessary to best create an environment that fosters recovery while minimizing the dis-

ruption to the family and child's lives. **Family therapy** and couples therapy are often very useful in this regard, and can address issues of parental roles, parental modeling, interfamily conflict, better communication, behavioral reward systems and defining family members' roles and responsibilities.

Education about childhood depression and its associated illnesses, nature, expectable course of the disorder(s), the importance and limitations of specific treatment modalities.

CASE:

When this patient came to me, we faced an unusual problem. My male assistant tried to take the case, but neither she, nor her mother gave any details to him. Finally my female assistant had to go and take the case!

8 and ½ years old girl, came on 21/1/05,

CHIEF COMPLAINT

1) Acute tonsillitis. Pain during swallowing on D1, D3: she develops fever upto 98 to 100° F. Palms become cold in winter. Along with throat she develops sneezing on 1st day, d2: watery discharge, D3: slight yellow thick discharge à cough and occasionally vomits out expectoration.

Episode is once a month, A/F chocolate and cold things, > warm water, child craves for warm water. When she is sick, she becomes dull. Talks in delirium if fever is high. Thirst is less. Throat is red and tonsils enlarged almost like a kissing tonsils.

1) Depression; Childhood. We were not getting the reason why she was suddenly not well. Further probing cleared the picture....She had the feeling of being rejected!

Imagine a 8 yr old saying these words! She had the feeling that the elder sister was loved more than her. Later on, when mother was questioned, she revealed that she has not expressed this but she could see her going into a shell since few years and not keeping well since then. This was definitely symptoms of depression in a 8 yr old.

OTHER COMPLAINTS

Since 2003 every day she feels constipated. Stools

1-2/day, not clear, though stools are not very hard she has to strain. Pain in rectum after passing stools. Often she gets pain in supra-umbilical region < empty stomach, < before going to stool. She passes offensive flatulence and there is also bloating of abdomen after food.

PATIENT AS A PERSON

HEIGHT: 4'3" . WEIGHT: 24 kg

Lean, fair skin, short hair, good looking girl.

SKIN: Dry. White spots on the face.

PERSPIRATION: Excessive

Dandruff +

TONGUE: Wet, coated

APPETITE: Normal

THIRST: Less

CRAVINGS: Chocolate, wafers, cream biscuits, spicy³, fish³, pickles³.

URINE: Bed wetting once in 3 months < winter.

OBSTETRIC HISTORY IN MOTHER: At 5th week there was threatened abortion. So mother was advised to have bedrest for 5 months. Took 12-13 USGs. Had to take lot of injections and medicines.

At 8th month the fetal movement reduced. So emergency LSCS had to be done.

MOTHER'S MIND DURING PREGNANCY

Irritable, elder brother confided to her about his problem. So patient had lots of worries along with anxiety and fear of this abnormal pregnancy.

Also mother was expecting a boy child, so mother was disappointed.

DEVELOPMENTAL LANDMARKS

Birth: 21 days earlier.

Birth weight: 2.5 kgs. Was chubby at birth

Walking at 1year 3 months

Speech delayed

Sleep: goes to sleep late and wakes up late in the morning

Occasionally talks in sleep

Physical reactions

Feels chilly in winter

Wants fan in summer and no fan in winter

Covering + in winter, ++ in summer.

Bath with warm water in all the seasons C4H1

LIFE SITUATION AND MENTAL STATE

Patient was leader of the class in Nursery- the *Dada* of the class. Used to solve other's problems. She was quiet and obedient.
 Very restless.
 Diplomatic at the same time very caring.
 Obstinate³.
 Intellectual – Very good at maths.
 Quarrelsome: Fights with elder sister.
 Wants pampering and attention. Mother has to listen to her.
 Egoistic: Would not go and call anyone.
 Stage fear: Would not go on stage.
 Would remain shy in new place or in front of strangers.
 Fastidious: Puts things very nicely.
 She does everything nicely so you do not feel angry on her. She knows how to convince others.
 Anger³ – Violent: pulls her hair, hits. < Contradiction.
 Weeping³: Mother says: crocodile tears
 Affectionate: Hugs and kisses, wants warmth. Sits in mother's lap often.
 Dominating³.
 Fear dark³, alone³.
 Anxiety ++
 Memory: Good
 >³ Company
 >³ Consolation

PAST HISTORY

Chicken pox
 Recurrent abdominal pain.

DIAGNOSTIC CRITERIA FOR DEPRESSION

We were not getting the reason why she was suddenly not well. Further probing cleared the picture....
 She had the feeling of being rejected!
 Imagine a 8 yr old saying this words! She had the feeling that the elder sister was loved more than her. Later on when mother was questioned she revealed that she has not expressed this but she could see her going in shell since few years and not keeping well since then.
 This was definitely symptoms of depression in a 8

yr old.
 tMark the other changes:
 the leader rather *Dada*, had become quiet.
 Obstinate³.
 Quarrelsome: Fights with elder sister.
 Wants pampering and attention.
 Egoistic: Would not go and call anyone.
 Stage fear-à Would not go on stage.
 Would remain shy in new place or in front of strangers.
 Anger³ – Violent: pulls her hair, hits.
 < Contradiction.
 Weeping³ à Mother says: crocodile tears
 Wants warmth.
 Sits in mother's lap, often clinging.
 Dominating³.
 Anxiety ++.
 >³ company
 >³ consolation

REPORTORIAL TOTALITY (Repertorisation by Robin Murphy)

- 1090 A/F Rejected feeling
- 0992 Affectionate
- 0997 Anticipation
- 1092 Restlessness, children in
- 1034 Domineering
- 1048 Fear dark
- 1044 Fear alone
- 1017 contradiction, intolerance of
- 1012 Desire for company
- 0996 Anger violent
- 1475 Tonsillitis
- 1429 Constipation children in
- Craving spicy
- Craving fish³
- Chilly

DRUGS ON REPERTORISATION

Lyc 23/10, Ars 21/10, Phos 21/9, Ign 17/8, Merc 15/8, Nux-v 15/8, Cham 15/8, Acon 12/8, Verat 12/8

PLAN

Acute: *Hep-s*
 Chronic: *Mag-ph*
 Intercurrent: *Tub-b*

FOLLOW UP CRITERIA

1. Tonsillitis
2. Fever
3. Sneezing
4. Discharge yellow
5. Cough+
6. Vomit
7. Restlessness

8. Constipation
9. Colicky pain
10. TV whole day
11. No friends, no play
12. Mother must listen to her
13. Wont talk to strangers
14. Skin: white spots
15. Fear dark
16. Fear alone – can't go alone to bathroom

TREATMENT

DATE	SYMPTOMS	REMEDY																																																																																																
21/1/05	Intercurrent.	<i>Tub-b</i> 1M 1dose																																																																																																
04/2/05	Cold since 2 days, yellow expectoration. Chilly.	<i>Hep-s</i> 200 4P, 1 dose every 4 hourly <i>Mag-ph</i> 200 1 st dose <i>Tub-b</i> 1M 1 dose																																																																																																
17/2/05	Cold >3. <table border="1" style="width: 100%; text-align: center;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td> </tr> <tr> <td></td><td></td><td></td><td></td><td>+</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>+</td><td>+</td><td>+</td><td>+</td><td>+</td> </tr> <tr> <td>L</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	1	2	3	4	5	6	7	8	9	1	1	1	1	1	1					+	0	0	0	0	0	+	+	+	+	+	L	0	0	0												5																																																			
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17/3/05	Throat and cold 5/3 > with <i>Hep-s</i> .	<i>Mag-ph</i> 200 2 nd dose																																																																																																
01/4/05	>3. Lazy—does not want to do anything except watch TV.	<i>Tub-b</i> 1M 1 dose																																																																																																
18/4/05	>3 except fear ³ . Hugging to mother. Craving junk food.	<i>Phos</i> 200 1 st dose																																																																																																
30/4/05	>3. No throat in spite of ice-cream.	<i>Phos</i> 1M 1 dose																																																																																																
19/5/05	Went to grand mother's place → constipation	<i>Phos</i> 1M 2 nd dose <i>Tub-b</i> 1M 1 dose																																																																																																
16/6/05	>. But fears ++	<i>Stram</i> 200 1 st dose																																																																																																
01/7/05	Cold +. Voice hoarseness+, watery discharge from nose. Does not want to participate. No activity except school	<i>Hep-s</i> 200 1dose 4 hourly <i>Tub-b</i> 1M 1dose																																																																																																
21/7/05	Fear dark, alone+. But goes to scholarship class alone. Constipation, tonsils is 0 since 5 months. White spots since 2 months.	<i>Mag-ph</i> 200																																																																																																