Childhood and Adolescent Depression

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Depression, a common symptom, syndrome, or disorder in children and adolescents, causes significant morbidity and occasional mortality through suicide.[1] The paper by Davis and his colleagues in this issue of The Journal calls attention to the common occurrence of childhood depression in a family practice population and the ease with which this problem may be overlooked in primary care.[2] When depression represents a symptom, the dysphoric mood, often related to a recent precipitating event, is usually relatively transient. The depressive syndrome, on the other hand, is more persistent. Depressive symptoms may also accompany such chronic illnesses as cancer, inflammatory bowel disease, asthma, and diabetes. Depressive symptomatology resulting from bipolar affective disorder occurs infrequently in this age period.

The child or adolescent generally does not think of his symptoms as associated with depression, nor does he spontaneously report that affect. Parents also usually do not recognize that their child or teenager is depressed. Consequently, the physician must suspect depression on the basis of the presenting symptoms, the history, and the patient's appearance and affect. If unaware of being observed, the patient's facial expression may be highly revealing. Other behavioral clues include neglect of grooming and personal hygiene, somber dress, flat affect, slow speech, gaze avoidance, and a mendicant posture. The depressed patient may also become tearful when an emotionally charged subject, situation, or person is mentioned.

When the physician suspects the presence of depression, he can quietly insert into the interview the empathic observation: "You know, Bruce, I have the feeling that things aren't going so well for you. . . ." The depressed child or adolescent will respond almost reflexively to this gentle comment by raising his head and making eye contact, almost incredulous that someome seems to understand. The physician can then follow up with the facilitative invitation: "Tell me about it. . . ."

Other useful, open-ended questions include: "Everyone worries from time to time. What are some of the things that *you* worry most about, Bruce?" or "Everyone gets pretty down sometimes. I'm interested in hearing about some of the things that make *you* sad. . . ." If the patient denies depressive feelings, the physician may respond with a remark such as: "Well, these things are always hard to talk about. You just seem to me to be kind of down . . . not feeling very good these days . . . and as your doctor, I'm very concerned (worried) about that." That the physician does not dismiss depression reassures the patient of the physician's interest and perceptivity.

Somatic symptoms are the most frequent reason for depressed children or adolescents to see the primary care physician. Presenting complaints such as a persistent headache, loss of energy, apathy, and chronic fatigue are particularly common, but others include abdominal, chest, or musculoskeletal pain (fibromyalgia), anorexia, weight loss or gain, bulimia, constipation, insomnia, hypersomnia, panic attacks, hyperactivity, irritability, inability to concentrate, an abrupt deterioration in school performance, and perhaps, a marked personality change.

The history may reveal gradual social withdrawal and isolation. The patient is reported to be less communicative, to spend an increasing amount of time in his room after school with the door closed, and to be easily provoked. There may be unusual and unexplained violent or rebellious episodes. Although the patient complains of being "bored," he no longer participates in sports or associates with or seeks out his peers. He may talk openly of death and suicide.

Anhedonia, an inability to have fun, and the patient's indifference to and loss of interest or pleasure in his usual activities is a major characteristic of childhood and adolescent depression. Poor self-esteem is reflected in feelings of being unworthy, unloved, helpless, and hopeless. The depressed patient may believe that no one likes or cares about him. He may view himself as having failed or been a burden on his family. Pessimistic about the future, the patient may have crying episodes for "no reason." Owing to excessive guilt, the child may be self-reproachful and self-depreciating. Social inhibition, perfectionistic striving, anxiety, truancy, running away, daredevil behavior, delinquency, school avoidance, conduct disorder, promiscuity, or substance abuse may also be reported.

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Often, depressed children and adolescents have experienced a major loss or a cluster of losses such as death of a close relative or friend, an unexpected termination of a girl or boy relationship, academic or other failure, an inability to maintain a high level of achievement or accomplishment, and parental divorce or remarriage. Other important stressors include failure to achieve admission to a desired college or career track, entrance to a new school without close friends, the first year in a college that is a long distance from home, and an unwanted pregnancy.

The second most important cause of death among adolescents aged between 15 and 19 years in the United States, with 1,700 deaths in this age group reported annually, suicide is a clinical and public health problem of great importance.[3] Neither the reason for the increased prevalence of suicide nor its cause are well understood. For every completed suicide, it is estimated that there are between 50 and 200 attempts.

In addition to the experiences listed above as associated with depression, risk factors or triggering events for suicide to which the physician must remain alert include alcohol or drug abuse, a psychosis, extreme family disruption, conflict with parents, poor impulse control, physical or sexual abuse, rape or physical assault, previous suicide attempts, a family history of suicide, suicide of a friend, media coverage of suicide (the so-called Werther effect of suggestion on suicide), a conduct disorder, and arrest, incarceration, or other experiences leading to shame, guilt, or humiliation.[4]

As there is no way to predict with certainty which child or adolescent will commit suicide, it is mandatory that the physician be alert to clues and take the time necessary to listen and hear the patient out. All suicide threats, gestures, and attempts are to be regarded as cries for help and taken seriously. Most young persons who subsequently die by suicide give prior warning. Those warnings must be heeded, and a prompt attempt made to determine the causes of the child's distress. Particularly ominous are written statements explaining why the adolescent feels that life is no longer worth living or reports that he has been giving away his personal possessions.

The physician who believes that his patient may be actively suicidal is obliged to pursue that suspicion with direct questions such as, "Have you thought about hurting or killing yourself?" "Have you thought how you would do it?" "Have you attempted suicide before?" "How do you think your death would affect your family?" Rather than precipitating a suicide attempt, such questions give the patient a chance to share his thoughts with a caring person and for the physician to judge the acuteness of need for mental health consultation or referral.

Immediate psychiatric hospitalization is mandatory for patients thought to be psychotic or actively suicidal. If uncertain about the possible lethal intent of a suicide gesture, most primary care physicians as the first medical line of defense against completed suicides will consult with a psychiatric colleague.[5]

References

1. Copoulose HK: Depression in childhood and adolescence. In Green M, Haggerty RJ (eds): Ambulatory Pediatrics III. Philadelphia, WB Saunders, 1984, chapt 36, pp 256–265
2. Davis TC, Hunter RJ, Nathan MM, et al: Childhood depression: An overlooked problem in family practice. J Fam Pract 1987; 25:451–457
3. Holden C: Youth suicide: New research focuses on a growing social problem. Science 1986; 233:839–841
4. Eisenberg L: Does bad news about suicide beget bad news? N Engl J Med 1986; 315:705–706
5. Cytryn L, McKnew DH: Treatment issues in childhood depression. Pediatr Ann 1986; 15:856–858