

# Childhood Depression: An Overlooked Problem in Family Practice

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To investigate the incidence and correlates of childhood depression in a family practice clinic, Kovacs Childhood Depression Inventory (CDI) was administered to 64 patients, aged 6 to 12 years. Accompanying parents completed the short form of Beck's Depression Inventory (BDI) and reported on the children's behavior problems. One half of the children studied scored within the depressed range on the CDI. Thirty-nine percent of the parents scored at least mildly depressed on the BDI.

Depression appeared to cluster in families. Every parent who scored in the severe depression range was accompanying a child who rated himself or herself as depressed. All parents who scored above the cutoff for mild depression rated their children as having behavior problems. Children's self-reported depression was also related to negative parental rating of the children's behavior.

Primary care physicians treat the majority of depressed patients who seek the aid of a physician.<sup>1</sup> Up to 42 percent of adult family practice patients rate themselves as at least mildly depressed on depression screening instruments.<sup>2-4</sup> As a result, adult depression is one of the ten most common problems seen by family physicians.<sup>5</sup> Psychiatric studies have shown that the children of families in which at least one parent has experienced a major depression have more perinatal problems, developmental difficulties, convulsions, accidents, injuries, operations, and behavioral problems.<sup>6</sup> Compared with matched controls, these children have an almost twofold increased risk for major depression, anxiety disorders, and suicide attempts.<sup>6,7</sup> Although depressed children are undoubtedly seen by family physicians, no studies of childhood depression have been reported in the family medicine literature.

Adult family practice patients rarely present with depression as their chief complaint. Instead, they report a variety of somatic symptoms, pain, and fatigue.<sup>8,9</sup> Children and adolescents come to the family physician with somatic or behavioral problems. In psychiatric settings children were formerly diagnosed as depressed based on

behavioral and somatic disturbances that varied with age and stage of development.<sup>10-13</sup> Depression in children was thought to include behavioral symptoms that masked the dysphoric mood. Masked depression proved to be difficult to validate; therefore, for research and clinical purposes, diagnosis of childhood depression has recently been based on criteria for adults as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, ed 3<sup>14</sup> (DSM-III) or the research diagnostic criteria (RDC).<sup>15,16</sup> DSM-III criteria for major depression are the same for infants, children, adolescents, and adults. The only difference between adult and childhood depression is the feature of separation anxiety that is associated with the latter. Some experts are now criticizing these criteria as being too limiting.<sup>17,18</sup>

In family practice, clinicians are aware that depression influences not only the illness behavior of the individual, but also the health and functioning of the entire family.<sup>19-21</sup> Psychiatrists have found that children with undiagnosed depression may have problems that interfere with their emotional, social, and academic development.<sup>22,23</sup> Families containing a member with undiagnosed depression use the health care system more often and accumulate inordinately high health care costs.<sup>24,25</sup> Failure to diagnose depression in these families can lead to frustrating and unrewarding experiences for both the family and the physician.<sup>26,27</sup>

Depression in children may be difficult to recognize in family practice settings. Children are not brought to the

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clinic with complaints of depression. Nonetheless, depressed children do have somatic, behavioral, and neurovegetative disturbances suggestive of depression.<sup>28</sup> In a primary care setting, however, screening a child for depression using a psychiatric interview may be unrealistic. Self-report inventories may prove to be useful tools for the busy family physician.

Psychiatric studies report that, when diagnosing depression in children, the child himself is the best single source of information.<sup>29</sup> Although the reliability of the child in reporting depressive symptoms has been confirmed,<sup>30,31</sup> the prevalence of depression in children in family practice clinics is unknown. Associated behavioral complaints have not been characterized, and family patterns of depression have not been explored in a family practice setting. To investigate these areas, methods previously used with adult family practice patients were replicated with parents and extended to their children.

The primary purposes of this study were (1) to determine the prevalence of depression among children in a family practice setting, as measured by the Childhood Depression Inventory (CDI),<sup>32</sup> and the prevalence of depression in parents accompanying these children; (2) to ascertain the extent to which depression clusters in families; and (3) to determine whether the parents of children with elevated depression scores perceive them to have more behavioral problems as measured by the Walker Problem Behavior Checklist.<sup>33</sup>

## METHODS

The subjects were 64 ambulatory patients of a university-based family practice setting that includes two clinics—one served by junior and senior medical students, and the other served by family practice residents. Both clinics are supervised by family physicians. Subjects were aged between 6 and 12 years (mean age 8 years), were of grossly normal intelligence, and had no serious or chronic disease. Children were accompanied by an adult (in most cases, a parent; in a few instances, a close relative with whom the child lived). The children were 52 percent male, 80 percent black, and 20 percent white. Based on their families' incomes, their socioeconomic status ranged from lower-middle to lower class. All accompanying adults were female except one, and all lived with the children whom they accompanied. Participation was solicited from both the accompanying adult and each child who visited the clinics during the months of March and April 1984 who met the criteria above. All of the children and adults who were asked agreed to participate.

The children took the CDI,<sup>32</sup> a 27-item, paper-and-pencil instrument developed by Kovacs as a scaled-down

version of Beck's Depression Inventory (BDI).<sup>34</sup> The CDI quantifies a wide range of depressive symptoms, such as mood, sleep, and appetite disturbance, interpersonal behavior, and suicide ideation. Several items concern the consequences of being depressed at school.<sup>32</sup> On the basis of symptoms included, the CDI overlaps considerably with the DSM-III and Feighner-derived Weinberg criteria,<sup>23</sup> which are the acknowledged standards for assessment of depression in children.<sup>31</sup> The CDI is one of the most frequently cited self-report instruments for the measurement of childhood depression.<sup>35</sup>

The accompanying parents took an abbreviated, 13-item version of the BDI, developed by Beck to aid family physicians in rapid screening for depression.<sup>36</sup> This version has been used extensively in Great Britain, where it was recommended for use by all family physicians in the British health service.<sup>37</sup>

The parents assessed their children's behavior using Walker's Problem Behavior Identification Checklist (WPBIC).<sup>33</sup> This instrument is a list of 50 observable maladaptive behaviors that fall into one of five-factor analytically determined scales: acting out, withdrawal, distractibility, disturbed peer relations, and immaturity. A score is given for each of these and for a total. The WPBIC is a useful screening device to identify children with problem behavior,<sup>38</sup> discriminating well between children with and without deviant behavior.<sup>37</sup>

The WPBIC was designed for elementary school teachers to identify children with behavioral problems and disorders. As most of the parents in this study did not read at college level, a simplified version was devised by substituting simpler words for some of those used in the original. To see whether the meaning of each question remained the same, two teachers rated eight children each, using both the original and the simplified version. No differences were found in the rating pairs.

After completing the tests, the child and adult were seen by their regular student or resident physician.

## RESULTS

Relationships between discrete variables were analyzed using McNemar's test for correlated proportions,<sup>39</sup> while relationships between continuous variables were analyzed using the Pearson correlation coefficient.<sup>40</sup> One-way analyses of variance and Duncan's Multiple Range test were used to evaluate differences among group mean scores.<sup>40</sup>

Of the 64 children studied, 32 (50 percent) scored within the depressed range on the CDI when using a cutoff of 11, the lower cutoff recommended by Kovacs for optimal sensitivity.<sup>32</sup> When a cutoff of 13 was used (the higher cutoff recommended by Kovacs for increased specificity),

**TABLE 1. PREVALENCE OF DEPRESSION, AS DETERMINED BY CHILDHOOD DEPRESSION INVENTORY AND BECK DEPRESSION INVENTORY**

Psychometric Instrument	Number of Subjects	Not Depressed	At Least Mildly Depressed
		No. (%)	No. (%)
Childhood Depression Inventory (cutoff of 11)	64	32 (50)	32 (50)
Childhood Depression Inventory (cutoff of 13)	64	43 (68)	21 (32)
Beck Depression Inventory (short form)	59	36 (61)	23 (39)

**TABLE 2. SUICIDE PRONENESS ASSESSED DURING ADMINISTRATION OF CHILDHOOD DEPRESSION INVENTORY (CDI)**

Question	Number of Subjects	Mean CDI Score
I do not think about killing myself	32	9.2
I think about killing myself, but I would not do it	28	11.7
I want to kill myself	4	24.5*

\* This mean was significantly different from the other two ( $P < .0001$ )

21 (32 percent) scored within the depressed range (Table 1). Only two of the children had an indication of depression recorded anywhere in their charts.

During the administration of the CDI, the children's responses to the question on suicide were noteworthy (Table 2). The CDI assesses suicidal tendencies by asking the child to assent to one of the following: (1) I do not think about killing myself; (2) I think about killing myself, but I would not do it; or (3) I want to kill myself. Of the 64 children tested, 28 indicated they have thought about killing themselves and 4 indicated that they wanted to kill themselves. The mean CDI score for the children who indicated they wanted to kill themselves was significantly different from the mean scores of the others ( $P < .0001$ ) (Table 2).

All of the 59 accompanying adults were tested with the short form BDI, and 23 (39 percent) scored above 5 (Table 1), the cutoff suggested by Beck for mild depression, while 6 (11 percent) scored above 16, the cutoff suggested for severe depression.<sup>36</sup>

All adults who scored within the severe depression range on the BDI were accompanying children who scored at least mildly depressed on the CDI (based on a cutoff of 11). Children's self-rating of depression correlated significantly with that of their accompanying adults ( $r = .27$ ,  $P < .03$ ).

There was a highly significant association between parents' self-reports of depression and their assessment of their children's behavior as being problematic ( $r = .61$ ,  $P < .0001$ ). A significant association ( $r = .36$ ,  $P < .003$ ) was also observed between the children's self-report of depression and parental rating of the children's behavior.

Sixty-nine percent (22) of the 32 children who rated themselves as depressed on the CDI (using a cutoff of 11) were rated by their parents as having problem behavior. Every parent who scored above the cutoff for mild depression rated his or her child as having behavior problems.

According to WPBIC scales, problem behaviors in the children that correlated most highly with parental depression were distractibility ( $r = .59$ ,  $P < .0001$ ) and acting out ( $r = .57$ ,  $P < .0001$ ). Withdrawal and disturbed peer relations were also significantly associated with parental depression ( $r = .45$ ,  $P < .0002$ ;  $r = .41$ ,  $P < .0009$ ). The children's self-report of depression was associated with parental ratings of the children's acting out ( $r = .40$ ,  $P < .0014$ ) and distractibility ( $r = .31$ ,  $P < .01$ ).

## DISCUSSION

In this primary care setting, the high prevalence of children rating themselves as at least mildly depressed on the CDI is disturbing. Although most of these children would not be diagnosed as having a major depressive disorder as defined by DSM-III or RDC criteria, they appear to be reporting some form of mild depression or depression proneness.

Studies in tertiary care settings have revealed similarly high prevalence rates of up to 50 percent of children scoring at least mildly depressed on the CDI. Over one half of these children (28 percent of the total) were diagnosed as depressed using DSM-III criteria. The children who were diagnosed as depressed had significantly higher CDI scores and a slightly more frequent family history of depression.<sup>30</sup>

What, then, is the mild depression that the CDI is identifying? Do family physicians need to concern themselves with it? CDI scores correspond to a broader range of symptoms than those listed in the DSM-III. Symptoms included in the CDI, such as low self-concept, anxiety, and teacher reports of acting out, may be consistent with a broader model of depression that includes masked depression.<sup>35</sup>

In this family practice clinic, which serves mostly poor families, higher CDI or BDI scores could also be associated with socioeconomic problems. In a national study of adult depression, Levitt and Lubin<sup>41</sup> concluded that individuals most likely to become depressed had an inferior educational background, a lower annual income, and an inability to improve their financial status over the years.

Higher CDI scores are associated with more severe depression; however, CDI cutoff scores cited in the literature are somewhat arbitrary, and their validity needs to be further evaluated in family practice settings. Furthermore, the clinical course of children with elevated CDI scores is unknown. These children may be at risk for developing more severe depression and behavioral or physical problems. Longitudinal studies are needed to assess clinically the natural course of mild depression in children and their families and to explore various intervention strategies with these patients.

In addition to the information conveyed by the overall score, specific CDI questions can aid physicians in interviewing young patients. Children's responses to the question on suicide can help physicians identify those who may require immediate attention, for whom a wait-and-see approach might prove dangerous. This question also may be useful as a quick screening device for depression (Table 2). All four of the children who scored positive for wanting to kill themselves had very high CDI scores. Only one of these children had a diagnosis of depression in her chart. The charts of the other three children indicated family stress or dysfunction. One child had a sister who died of sudden infant death syndrome within the last year. The other two children were siblings, and the child protection agency had been notified that the 7-year-old sister had a vaginal culture positive for *Neisseria gonorrhoeae*.

Although the absolute number was small, the most striking finding of the current study was that all of the adults who rated themselves as severely depressed had children who also scored as depressed. This finding suggests that the family physician who diagnoses depression in an adult patient would be well advised to assess the mental health of the children in the family.

The child's problem behavior, as rated by the parent, was significantly related to the child's self-assessment of depression. Behavioral problems, acting out, and school difficulties may signal underlying depressive reactions in children.<sup>10,11,13</sup>

The parents' depression scores related more strongly to their rating of their children's behavior (in such areas as distractibility, acting out, withdrawal, and disturbed peer relationships) than did the children's depression scores. This finding suggests that behavioral problems in children may be a predictor of depression in the mother as well as in the child.

In the normal course of well-child care, physicians make various inquiries about child behavior. Pertinent responses

to these inquiries could cue the physician to look for depression in the family.

## CONCLUSIONS

One half of the children who visited this residency-based family practice clinic scored in the depressed range of a self-report depression screening inventory. A high proportion of the accompanying parents of these children had elevated scores on a self-reported depression test. Behavioral problems in children, particularly acting out and distractibility, may be useful indicators of depression in the child and in the parent as well.

Self-report measures, such as the Childhood Depression Inventory, may be useful tools to help busy physicians identify possible depression or depression proneness in their young patients. Family physicians who suspect depression in any patient, whether adult or child, are advised to consider the possibility of depression in other family members and are encouraged to follow through with appropriate assessments.

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## Commentary

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Some years ago David Goldberg suggested the phrase "hidden psychiatric morbidity" to refer to the substantial numbers of adult cases of psychiatric morbidity that go unrecognized in primary care practices.<sup>1</sup> Now a new literature is developing concerning the same problem among children seen in these settings. One of the most striking findings in the preceding paper by Davis and colleagues is that of 64 children in their sample, 21 scored in the depressed range, but only 2 had any indication of depression anywhere in their charts. If chart notations are meaningful, 90 percent of the morbidity in these cases remained hidden or "overlooked." This study and others in the adult literature should at least alert us to this problem and perhaps suggest a focus for future studies.

Davis and co-workers have initiated in a family practice

setting an investigation of childhood depression that addresses three issues: it undertakes to examine the prevalence of depression among children aged 6 to 12 years attending the center and among the parents accompanying these children, to assess the clustering of depression in families, and, finally, to determine whether parents of depressed children perceive them to have more behavioral problems. Each of these topics is important and deserves to be a focus of attention in its own right.

The authors found that from 32 to 50 percent of the children studied scored in the depressed range on the Childhood Depression Inventory. These percentages may be somewhat exaggerated, as the cutoff scores are fairly low<sup>2</sup> and the entity being called depression may overlap with anxiety or other conditions.<sup>3</sup> Nevertheless, the figures

are in the range found in the adult population,<sup>4,5</sup> and are of more concern because the patients' mean age is only 8 years. Davis and colleagues also found that one half of the 59 accompanying adults self-reported mild to severe depressive symptomatology. This finding is certainly higher than one would expect in the general adult population based on the ECA studies of the community at large.<sup>6</sup>

Several investigations have indicated that depression clusters in families,<sup>7,8</sup> and the present report also found this clustering to be the case. All severely depressed adults were accompanying children who were mildly depressed at least, and the children's self-rating of depression correlated significantly with that of the accompanying adults. A perspective such as that presented by Engel's biopsychosocial model<sup>9</sup> might have led the investigators to hypothesize this finding. If one individual in the family (in this case the child) is depressed, one might suspect from a genetic, psychological, or social basis that other members will have at least an increased likelihood of displaying depressive symptoms. Unfortunately, this approach still leaves us with the question of etiology, but is more holistic. Perhaps more fruitful in terms of family clustering would be an interview of all family members of the index cases (the children), not just the accompanying adult, to examine for depression and a wider range of disorders among the parents, including, for instance, alcoholism. It may be, as family therapists have noted, that the child is bringing the family to treatment.<sup>10</sup> If so, the higher prevalence of depressive symptoms may best be seen as an expression of family pathology rather than individual pathology.

The third aim of the study is an effort to determine whether "parents of depressed children perceive them to have more behavioral problems." The question itself is somewhat perplexing. It is not clear with whom the comparison is being made: the parents' other children, those children in the study without depressive symptomatology, or the children's peers known to the parent. Certainly the debate over symptomatology in childhood depression is properly recognized by the authors. Added to this problem, however, is the depression of the parent-rater in the present study. The observation that 100 percent of these parents, who are themselves in many instances depressed according to the Beck Depression Inventory, rate their children as having behavior problems does not seem to advance the argument. The association between parents' self-report of depression and their children's problem behavior compared with that of the children's self-report of depression and their problem behavior appears to be much stronger ( $r = .61$  vs  $r = .30$ ). This association perhaps has more to do with the observer than the observed. It would be interesting to know what percentage of the 32 children who did not rate themselves as depressed were seen as having behavior problems by their parents, and whether those percentages differ significantly when parents are de-

pressed compared with those who are not depressed. The authors do present data indicating that the problem behaviors identified tend to be different when the parent is depressed vs when the child is depressed. This finding strikes us as important. Such distinctions may ultimately serve as clues to the family physician seeking to assess and treat the family and to separate one member's morbidity from another's, insofar as possible or appropriate.

The problem of underrecognition of psychiatric morbidity in the primary care setting has been well documented in the literature.<sup>1,11</sup> One investigative approach to the problem has been to ask what attributes of the patient or physician<sup>12,13</sup> are associated with underrecognition. Physician characteristics such as sex and psychiatric education appear not to yield much insight. Patient characteristics such as education and economic status also have not been highly correlated with underrecognition. While there may be physician characteristics that remain to be explored further, it seems most likely that the answer lies in the decision-making process wherein a physician scans a variety of data, selects certain clues as high priority, and makes decisions about diagnosis and management accordingly. This process of reading the clues occurs as an interaction between the physician and the patient, and in the case of children, usually includes the patient's parent. There are indications that the clues physicians use may be the wrong ones. Costello,<sup>14</sup> in an unpublished paper, reported that certain clues pediatricians use to help identify disturbed children were remarkably ineffective in helping pediatricians identify the disturbed children. In Costello's study over 80 percent of significantly disturbed children went unidentified by their pediatrician.

Another approach to the problem of underrecognition has been to utilize self-report screening devices and give feedback to physicians just prior to the examination so that their recognition of the "hidden psychiatric morbidity" will be heightened. While a few studies have found positive results,<sup>15-17</sup> most have been modest and some have found none at all.<sup>18,19</sup> Hankin reported at a recent mental health conference on the results of a study<sup>20</sup> in which the impact of feedback from the Child Behavior Checklist on psychosocial management of the child by pediatric providers was measured. A modest positive effect on management was found, especially when the psychosocial problems had not been previously recognized by the provider, but again the effect was only modest.

One pitfall of focusing on self-report questionnaires is the implication that the problem of underrecognition lies with the patient's expression of symptoms, that the disorders are indeed hidden by the patient. More likely the problem lies with the physician who overlooks the problem. The authors of the present study suggest that "self-report measures may be useful tools to help busy physicians identify" psychiatric morbidity. The inference is that the identification of mental disorder in the primary care

setting is not yet on a par, in the physicians' minds, with other medical problems. Until the dichotomy between "organic" and "mental" and their presumed variable contribution to human suffering is resolved, it is likely that much psychiatric morbidity will remain "overlooked."

The study reported here does a great service in addressing the problem of a substantially underrecognized disorder in a younger population. Childhood depression, however, may not represent an individual disorder so much as an expression of family pathology. There is a clear opportunity here for family physicians to develop an important body of knowledge concerning the significance of what is being expressed by these children and its eventual integration in the management of both children and families.

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