Depression in children and young people

Raphael Kelvin

Abstract

Depression is a common and important health problem affecting the lives of many children and young adults. For many sufferers it has its roots in later childhood. The incidence increases sharply from early adolescence onwards. Depression manifests with increasing frequency as early adult life approaches and represents an escalating set of impairments across personal, family, social and educational life of children and young people. Its under-detection and under-treatment in the UK NHS is a major public health and personal safety issue, deserving of attention. The longer term societal implications are significant in terms of lost education opportunity, decreased earnings, personal distress and risk of subsequent mental ill and indeed physical ill health outcomes. This article seeks to alert the clinician to the symptomatology and thereby assist in righting this major health inequality, so that the future of depression care can be different from the past, and closer to 'parity of esteem' with the care deemed routine for major debilitating common physical health conditions in the UK.

Keywords child; children; depression; depressive disorder; formulation; young people

Introduction

What is depression?

Depression represents a cluster of presentations characterized by disturbances of the body, affect and associated cognitions. The disturbances of the body, otherwise known as somatic symptoms or physiological symptoms, represent perturbations of the fight flight or freeze mechanisms and or of the motivational, appetitive and diurnal body clock systems, such as sleep and energy levels. These disturbances can be mapped using functional MRI (fMRI) to fronto-limbic and hypothalamic-pituitary systems and necessarily involve a range of neurotransmitter and neuro-hormonal correlates amongst which the serotonin, dopaminergic, noradrenergic, and melatonin, corticosteroid are prominent but probably only represent a partial understanding of the immensely complex brain chemistry at play.

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The disturbances of affect manifest as over-arousal of generally negative emotional states like fear, anger, irritability and sadness. The cognitive and neurocognitive components are wider-ranging than many clinicians and educationalists recognize and include disturbances of attention, concentration, motivation, processing speeds, and generally 'executive' functions such as decision-making. In the most severe cases the fixed beliefs that emerge come close to or involve a psychotic depressive illness.

Why do young people suffer from depression?

Depression is usually triggered by one or more negative *events involving* stress, loss, or disappointment; but they are not usually the entire cause. Additional *risk factors* categorised as *vulnerability factors increase the impact of such adverse events, these* may be difficulties in family relationships or friendships, long-term problems at school, difficult events earlier in life, and personality traits of the child/adolescent (including being a bit shy, being perfectionist and being more emotional than the average child).

There is considerable clinical and aetiological overlap between the anxiety disorders and depression. It is likely that the degree of overlap and the associated clinical heterogeneity represent the fact that current diagnostic groupings will require re-evaluation when the fruits of the new neurosciences become available.

When and where does it occur?

Depression incidence increases sharply from early adolescence onwards. There are some specific incident onset differences from other childhood disorders with depressions showing escalating emergence from middle childhood and sharply upwards through adolescence into early adult life. At least 3% (range of study estimates 3–9%) of adolescents will develop depression in any 12-month period so in an average class of 30 adolescents, 1–2 will have clinical depression. There is gender ratio of 2:1 girls to boys in adolescents. In childhood, ages 7–11 years the rate is 1% and is equally common in boys and girls.

How can it be treated?

Early effective intervention is important to improve time to remission and prevent secondary illness effects such as poor physical health hygiene, education impairment, persisting relationship difficulties and complicating antisocial tendencies-delinquency. Depression is amendable to treatment. There are significant continuities for both depression and its secondary consequences, into adult life. This leads to one of the largest costs to society amongst all health conditions, across the world. Effective detection and treatment is vital.

Treatments generally start with psychosocial interventions and talking therapies, with medication used in selected and more severe subgroups. There are a few very severe subgroups where use of medication is advocated from diagnosis but never without good clinical psychosocial care. Subgroups requiring medication are defined by presentation severity and associated impairments, lack of response to first line talking therapies within specified time frames, deterioration during talking therapies, and overall presentation including comorbidities.

Who requires further investigation?

There is a limited role for laboratory or radiological investigations, but it is helpful to bear in mind that there are important disease processes which can result in low mood. Features in the history which suggest thyroid or cardiac disease should prompt further investigations e.g. thyroid function tests and ECG.

Assessment and management

Depression is a 'common mental disorder'. In children and adolescents it can interfere with the developmental trajectory impairing educational experiences and close relationships (see Figure 1). In turn, this can have enduring consequences to self-confidence, self-worth, and capacity to form good relationships.

The secondary effects of depression in children and adolescents can persist into adult life and become risk factors for subsequent depressions, as well as onsets of adult personality disturbances and disorders. There is the much increased risk of self-harm and suicide.

Detection and referral rates

Unfortunately, services are not very good at detecting depression in children and adolescents. Some reports have found up to 50% of cases presenting to GPs in UK NHS primary care are missed. Paediatricians probably fare little better. There is much to do! The features of depression are summarized in Box 1 (below).

Detection in primary care and subsequent referral rates from primary care to specialist care remain very low; no more than 25% of all cases of psychiatric disorder get any appropriate treatment at any level of service (ONS, 2003). Parsimonious estimates for depression indicate unmet need in around 120,000 children and young people.

What does depression look like?

A quote from Callum a mental health ambassador from Right Here Sheffield is very telling.

> *"I wish I knew before my GCSE years got wasted. I wish I knew before I got expelled, but I didn't and my life would have been better if I did. Teachers told me all the angles of a triangle add up to 180……but they never told me its ok to be depressed…not to feel ashamed…mental health is something we all have"*

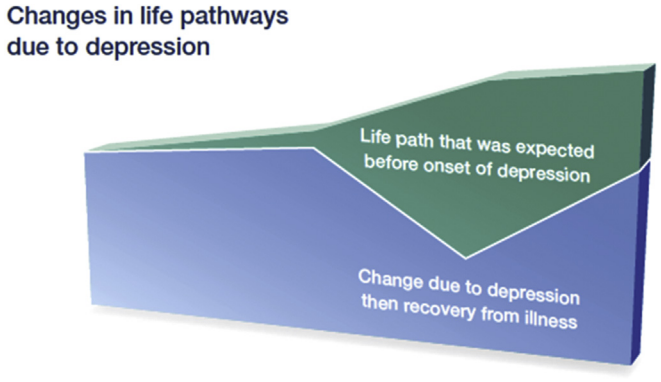

Figure 1 Developmental pathway consequences of an episode of depression.

Spotting depression: What to look out for and what to worry about

Children and young people who are regularly reported to be

- Feeling sad
- Seeming angry, grumpy or short-tempered
- Getting less pleasure from life
- Not concentrating
- Easily prone to tears
- Like a flat battery, low on energy
- Not eating meals
- Keeping unusual hours with sleep
- Easily bored and disinterested, losing motivation and zest for life
- School performance and/or grades have been dropping
- Not wanting to mix much with the family and/or friends
- Falling out a lot with friends and teachers
- Low on self-esteem and confidence
- Very negative about things they used to be positive about
- Has aches and pains not explained by a physical illness
- Has unusual feelings of guilt or self-blame
- Has ideas or speaks about life not being worthwhile, harming self or ending of life

Hazardous behaviours that may occur

- Self-harm
- Suicide attempts
- Use of alcohol, cigarettes and/or illegal drugs
- Doing dangerous things without thinking of the consequences (like crossing the road without looking)

These behaviours can be

- Caused by the depression
- Or get worse in those already engaged in such hazards

Box 1

A missed opportunity to make a diagnosis of depression and take action can have profound consequences for the individual. Once suspected, the diagnosis can be made by identifying the clinical features summarized in Table 1.

How are the symptoms of depression expressed in everyday life?

The experience of depression is different for each young person and their family. Therefore, it stands to reason that the