Depression and suicidal behaviour in children

Richard Harrington

Depression is a psychiatric disorder, while suicidal behaviour is a symptom of many different kinds of problem. However, it is convenient to consider them together because they are strongly associated and often require similar management strategies.

Depression

Definition: for many years depressive disorder in children and adolescents was diagnosed using different criteria from those used with adults; now, most clinicians use one of the major adult diagnostic schemes – DSM-IV and ICD-10. At the core of the concept is an episodic disorder of varying degrees of severity that is characterized by depressed mood or loss of enjoyment that persists for several weeks. The individual must also experience other symptoms during the episode. These include depressive thinking, such as pessimism about the future or suicidal ideas; and biological symptoms, such as early waking, reduced appetite and weight loss.

Epidemiology: depression is very uncommon in pre-adolescent children but the rates increase greatly during adolescence to reach a prevalence of around 1% in boys and 2% in girls. It is thought that the prevalence of depressive disorders may be increasing among young people. Depressive disorder usually occurs in conjunction with other psychopathology, especially anxiety and conduct disorder.

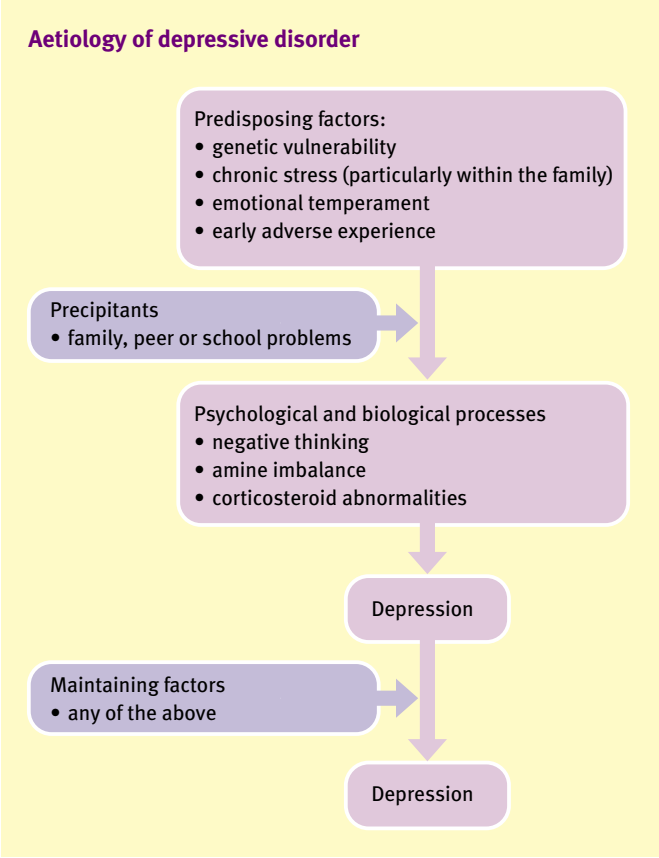
Aetiological factors: the aetiology of depressive disorders among young people (see Figure 1) is not fully understood, but the available evidence suggests that the cause is a combination of:

- predisposing constitutional factors arising from genetic endowment or earlier experience
- precipitating stressful events.

These aetiological factors act through biochemical and psychological processes to produce the depressive syndrome. Once established, the syndrome is often prolonged by maintaining factors such as negative thinking or continuing adversity.

Course: around one-third of untreated cases will remit spontaneously within 1–2 months. For the remainder, however, remission can take many months, and around 10% are still depressed after 1 year. In severe cases the risk of relapse is at least one-third, and further episodes will often occur in adulthood.

The most serious complication of adolescent depression is suicide (risk of about 3% over the next 10 years). Other complications of depressive disorder are usually seen when it has been present for a prolonged period, and include poor school performance and impaired relationships.



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Diagnostic assessment

The diagnosis is made from a mental state examination conducted by the psychiatrist interviewing the adolescent alone. In the early stages the most difficult aspect of diagnosis is distinguishing depressive disorder from the depressive symptoms that are commonly reported by adolescents and are usually of no psychopathological significance. Depressive disorder should therefore be diagnosed only in the following instances:

- when there is impairment of social role functioning
- when symptoms of unequivocal psychopathological significance are present (such as severe suicidality)
- when symptoms lead to significant suffering.

Differential diagnosis – another diagnostic issue arises from the fact that depressive disorder often occurs in conjunction with other psychiatric problems. Indeed, one of the best discriminators between young people with any form of psychiatric disorder and those with no psychiatric disorder is the symptom of depression. Moreover, some of the symptoms that are part of the depressive constellation may arise as a symptom of other disorders; restlessness, for example, is seen in agitated depression, hypomania and

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hyperkinetic syndrome. As a general rule, the double diagnosis should be made only when symptoms that are not simply part of another disorder clearly indicate the separate presence of a depressive disorder.

Management

The aims of management are:

- to treat the depressive disorder
- to minimize the risk of complications
- to manage risk factors
- to prevent relapse.

Initial management depends largely on the nature of the problems identified during the assessment procedure. This may indicate that the reaction of the child is appropriate for the situation. In such a case, and if the depression is mild, an early approach can consist of sympathetic discussion with the child and the parents, simple measures to reduce stress and encouraging support. Around one-third of mild or moderately depressed adolescents will remit following this kind of brief, non-specific intervention.

Persistent depression will require more specific and lengthy forms of treatment (Figure 2). The first-line treatments for mild or moderate depression (depression causing moderate social impairment) are usually psychological. More severe cases will usually require antidepressant medication.

Minimizing complications may involve other kinds of interventions. For example, school refusal arising from depression may require attendance at a special unit, such as a pupil referral unit, or home tuition. The risk of suicidal behaviour should be assessed regularly.

Managing the context – an important component of treatment is the management of the stresses that are associated with many cases of major depression. It is sometimes possible to alleviate these stresses; for example, bullying at school may be reduced by a discreet telephone call to the head teacher, or by some other intervention with the school. Maternal depression may resolve with antidepressant treatment.

However, in many cases, acute stressors are among a number of causes of the adolescent's depression. Moreover, such stressors commonly arise out of chronic difficulties, such as family discord, and may therefore be very hard to remedy. Symptomatic treatments for depression can therefore be helpful even when it is obvious that the depression occurs in the context of chronic adversity that is likely to persist.

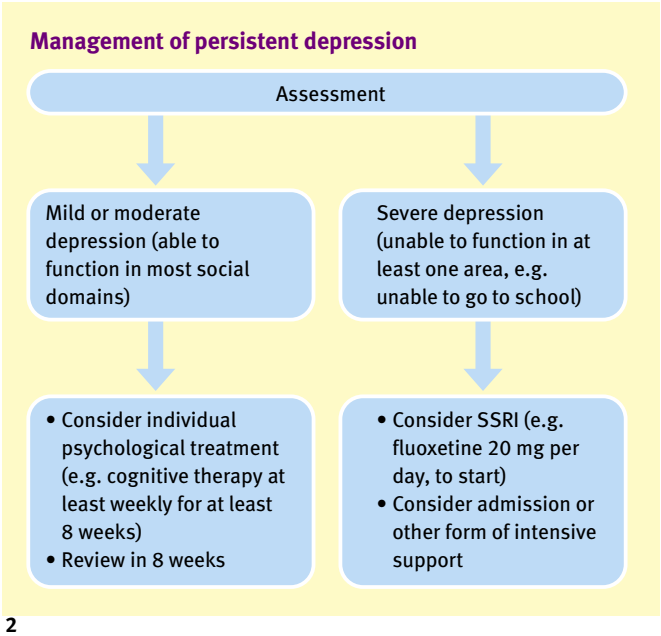
Prevention of relapse – if medication achieves remission, it should be continued for 6 months. Continuation of psychological treatment is also helpful, provided therapy resources are available. Little is known about the best ways of preventing relapse in the long term. The patient and parents should be advised about the early signs of relapse and encouraged to return to the clinic quickly if signs appear. Short courses of antidepressant initiated early in a relapse will help to reduce duration. Patients with several risk factors for relapse, such as a history of previous relapses or a strong family history of recurrent depression, may require long-term maintenance treatment with antidepressants.

Treatment of resistant depression

Treatment resistance is defined as failure to respond to an adequate course of a treatment that has been shown to be effective in clinical trials. Such treatments include selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine and paroxetine, and individual psychological therapies, such as cognitive–behavioural therapy (CBT) and interpersonal psychotherapy (IPT).

The first step in assessing treatment resistance is to review compliance with the initial treatment. The results of the initial diagnostic assessment should also be reviewed; for example, is there evidence of ongoing stressors such as abuse? If the review shows that the initial diagnosis was correct and that an adequate course of treatment was given, then other treatments should be considered (Figure 3).

Failure to respond to psychological treatment is usually an indication for a trial of an SSRI. Failure to respond to an adequate course of one SSRI should usually be followed by another course of a different SSRI.[1] Failure to respond to two SSRIs is an indication for other antidepressants of a different class, such as venlafaxine.



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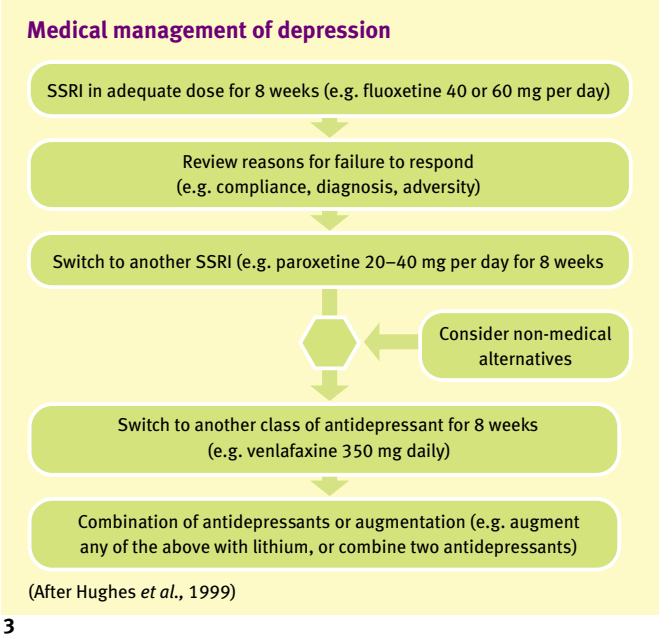

(After Hughes *et al.*, 1999)

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