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Depression in school-age children and adolescents: Characteristics, assessment and prevention

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Untreated depression. It's the number one cause of suicide today, including among young people.

The statistics are startling. As many as 8 percent of adolescents attempt suicide today. And completed suicides have increased by 300 percent over the last 30 years. (Girls make more attempts at suicide, but boys complete suicide four to five times as often as girls.) It is also known that 60-80 percent of suicide victims have a depressive disorder. A 1998 study showed, however, that only 7 percent of suicide victims are receiving mental health care at the time of their death.

Characteristics of depression

Up until about 30 years ago, many in the field of psychology believed that children were incapable of experiencing depression. Others believed children could be depressed, but would most likely express their dysphoria indirectly through behavior problems, thereby "masking" their depression.

Three decades of research have dispelled these myths. Today, we know that children experience and manifest depression in ways similar to adults, albeit with some symptoms unique to their developmental age.

Children can experience depression at any age, even shortly after birth. In very young children, depression can manifest in a number of ways including failure to thrive, disrupted attachments to others, developmental delays, social withdrawal, separation anxiety, sleeping and eating problems, and dangerous behaviors. For the purposes of this article, however, we will focus on school-aged children and adolescents.

In general, depression affects a person's physical, cognitive, emotional/affective, and motivational well-being, no matter their age. For example, a child with depression between

Table 1

Developmental variations in the characteristics of depression

Ages 6-12	Ages 12-18
somatic (generalized bodily)	suicidal thoughts
complaints	hopelessness
school difficulties	social isolation
negative self-statements	drug/alcohol use
fatigue	sexual acting out
boredom/apathy	overeating and oversleeping
eating disturbance	rage
lack of motivation	
decreased concentration	
anxiety	

the ages of 6 and 12 may exhibit fatigue, difficulty with schoolwork, apathy and/or a lack of motivation. An adolescent or teen may be oversleeping, socially isolated, acting out in self-destructive ways and/or have a sense of hopelessness. (See table 1.)

Prevalence and risk factors

While only 2 percent of pre-teen school-age children and 3-5 percent of teenagers have clinical depression, it is the most common diagnosis of children in a clinical setting (40-50 percent of diagnoses). The lifetime risk of depression in females is 10-25 percent and in males, 5-12 percent.

Children and teens who are considered at high risk for depression disorders include:

- children referred to a mental health provider for school problems
- children with medical problems
- gay and lesbian adolescents
- rural vs. urban adolescents
- incarcerated adolescents
- pregnant adolescents
- children with a family history of depression

Diagnostic categories

Transient depression or sadness is not uncommon in children. For a diagnosis of clinical depression, however, it must be causing an impairment in the child's ability to function. Two primary types of depression in children are dysthymic disorder and major depressive disorder.

Dysthymic disorder is the less severe of the two, but lasts longer. The child exhibits chronic depression or irritability for more than a year, with a median duration of three years. Onset typically occurs at about 7 years of age with the child exhibiting at least two of six symptoms (see table 2). A majority of these children go on to develop a major depressive disorder within five years, resulting in a condition known as "double depression." However, 89 percent of pre-teens with untreated dysthymic disorder will experience remission within six years.

Major depressive disorders have a shorter duration (greater than two weeks, with a median duration of 32 weeks) but are more severe than dysthymic disorders. A child with major depressive disorder exhibits at least five of nine symptoms, including a persistent depressed or irritable mood and/or a loss of pleasure. Typical onset for major depressive disorder is 10-11

Table 2

Symptoms of dysthymic and major depressive disorder

Dysthymic disorder	Major depressive disorder
Depressed or irritable mood	Persistent depressed or irritable mood
Poor appetite or overeating	Diminished interest or pleasure in most activities
Insomnia or hypersomnia	Loss of appetite and/or noticeable weight loss or gain
Low self-esteem	Insomnia or hypersomnia
Poor concentration or indecisiveness	Restlessness or feeling of being slowed down
Feelings of hopelessness	Fatigue/loss of energy
	Feelings of worthlessness/guilt
	Decreased concentration
	Thoughts of death, suicide ideation and/or attempts

years of age, and there is a 90 percent rate of remission (for untreated disorders) within one and a half years.

The prevalence of depression increases with age, affecting as many as 5 percent of all teenagers, and as many as one-in-four women and one-in-five men in adulthood. Fifty percent of those with a major depressive disorder will have a second episode in their lifetime.

In many cases, depressive disorders overlap with other diagnoses. These may include: anxiety disorders (in one-third to two-thirds of children with depression); attention deficit hyperactivity disorder (in 20-30 percent); disruptive behavior disorders (in one-third to one-half of patients); learning disorders; eating disorders in females; and substance abuse in adolescents.

Table 3

Symptoms of dysthymic and major depressive disorder

Behavioral	Emotional	Statements
Noticeable changes in appetite, weight, sleep, use of alcohol / chemical subs., academics, work, sexual patterns, social and/or religious activities	Withdrawal, sulkiness	"I won't be around much longer."
Lack of energy, lethargy, fatigue	Feelings of helplessness and hopelessness	"_____ would be better off without me."
Loss of pleasure in usual activities	Crying spells, tearfulness, sadness	"I just can't take it anymore."
Decreased concentration and lack of interest	Low self-esteem, unreal expectations of self	"Nobody would miss me if _____."
Hyperactivity, restlessness	Pronounced mood swings	"I'm going to end it all."
Somatic complaints	Anxiety	"Who'd care?"
Withdrawal	Feelings of loss	"I want to die."
Frequent, unexplained, irrational changes in behavior	Feelings of powerlessness, out-of control, outside control	"They'll be sorry when I'm gone."
Impulsiveness and recklessness	Feelings of isolation, loneliness	"I just want to lay down and sleep forever."
Aggressiveness	Depression	"It won't be long before this pain is gone."
Giving away favorite or prized possessions (a "living will")	Sudden happiness following depression	"Did you ever wonder what it would feel like to be dead?"
	Guilt, remorse, self-reproachment	"I'm going to commit suicide."
	Nervousness	
	Despondency	

The risk of suicide

As mentioned above, the rate of suicide has increased three-fold since the early 1970s, and is the major consequence of untreated depression. It is a trend that demands greater awareness, in order to prevent these deaths and better treat those at risk.

Completed suicides are rare before the age of 10, but the risk increases during adolescence. Risk factors include psychiatric disorders such as depression (often untreated), substance abuse, conduct disorders, and impulse control problems. There are many behavioral and emotional clues that can also be signs that a young person is at risk for suicide. (See table 3.) A lack of coping skills and/or poor problem-solving skills are also risk factors that should not be overlooked. Drug and alcohol abuse is prevalent among those who commit suicide. Approximately one-third of young people who commit suicide are intoxicated at the time of their death. Other risks include access to firearms and lack of adult supervision.

Stressful life events, such as family conflict, major life changes, a history of abuse and or pregnancy are also factors that can trigger thoughts of suicide and even action. If a young person has attempted suicide in the past, there's a good chance they will try again. More than 40 percent will go on to make a second attempt. Ten to 14 percent will go on to complete a suicide.

Unfortunately, suicide can be difficult to predict. It is important to pay close attention to any child or teen who exhibits "clues" for suicide as presented in table 3. For someone at risk for suicide, a precipitant may be a shameful or humiliating experience such as the break-up of a relationship (19 percent), conflicts over sexual orientation, or failure in school. Another "trigger" for suicide may be ongoing stressors in life, with a sense that things will never get better.

Assessment, treatment and intervention

Assessment for childhood depression begins with initial screening, typically by a child psychologist, using a measure such as the Children's Depression Inventory (Kovacs, 1982). If the assessment is positive, classification includes further assessment for symptoms listed previously, the onset, stability and duration of symptoms, as well as family history. It is also important to assess the child for anxiety disorders, ADHD, conduct disorders, etc; school performance; social relationships; and substance abuse (in adolescents).

Alternative causes for the child's depression should also be considered and ruled out, including causes associated with the child's developmental and medical history.

Targeting those children and teens who are at high risk for depression, or who are facing high-risk transitions (such as moving from grade school to junior high) is key to prevention. Protective factors include a supportive family environment and an extended support system that encourages positive coping. *The Optimistic Child*, by Martin Seligman, 1995, is a good book to recommend to parents on preventing depression and building a child's coping skills.

Interventions for diagnosed clinical depression can be highly successful and include both medications and individual and family therapy.

If there are any concerns that a child or adolescent may be suicidal:

- Do not hesitate to refer them to a mental health professional for assessment. If immediate assessment is needed, take the child to the emergency room.
- Always take threats of suicide seriously.
- If the child has stated an intent to commit suicide, and has a plan and a means to carry it out, they are at very high risk and need to be kept safe and supervised in a hospital.

The major “treatment” for suicidal behavior is to find and treat the underlying cause of the behavior, whether it’s depression, substance abuse, or something else.

Conclusion

While 2–5 percent of children and adolescents experience clinical depression (nearly as many kids as have ADHD), it is often “missed” by those around them, because it can be less obvious than other more disruptive behavior disorders. Left untreated, it can have a significant negative impact on development, well-being and future happiness, with untreated depression being the major cause of suicide. However, with treatment, including medications and/or psychotherapy, the majority of patients show improvement, with a shorter duration of their depression and a reduction in the negative impact of their symptoms.