

DEPRESSIVE ILLNESS IN CHILDREN—A REVIEW

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True or pure depressions as seen in adult are very rare in children. However, recently, there have been many reports from various psychiatric clinics about childhood depressions and it has been more or less accepted as a clinical entity though not yet included in official classification. Historically sadness or despondency in children was recognised in the 17th century and suicide and melancholia were noted in children by the middle of 19th century. Manic depressive psychoses was reported in children only in early part of 20th century.

Kraepelin (1921) reported that in a sample of 900 patients 0.4% had their attack of manic depressive episode before the age of 10 years.

Barrett (1931) found that the onset of manic depressive illness in earlier years was more frequent than what had been thought of by others. Of 100 cases of manic depressive psychoses under 20 years, 5% had their 1st attack before the age of 12 years. Bradley (1937) felt that true depression does not occur in childhood and that manic depressive psychoses is very rare and of questionable existence before puberty.

Kanner (1948) also felt that full fledged depressive illness seen in adults is very rare in children. Campbell (1952) studied 18 children (11 girls and 7 boys) with manic depressive psychoses over a period of 2 to 6 years and emphasised the frequency and importance of this psychosis among children, the strong familial tendency of the disease, the reversible nature of the mental illness and the overemphasis that has been placed on environmental and dynamic factors in the psychiatric illness of children. He felt that cyclothymic personality and manic depressive psychoses

among children are too often diagnosed as psychoneurosis or schizophrenia or the patients are classified as problem children.

Depression in infancy was noted as an effect of deprivation by Levy (1937). He studied a group of children who in their earliest years had received little or no maternal love and found that their affect was shallow and that they shared various neurotic symptoms. Levy described them as suffering from affect hunger due to deficient social relationship and they showed persistent relationship difficulties such as delinquent behaviour. Subsequently Spitz & Wolf (1946) observed a special condition in the nursery and described it as "anaclitic depression". This occurred in infants and small children who were isolated from maternal care. Such infants in the 2nd half of 1st year of life developed a weepy, then a withdrawn, then a rigid behaviour along with insomnia, illness and loss of weight. They took on a far away, dazed expression and showed increased disturbance and screamed when an adult tried to make contact. Nineteen out of the 123 infants showed this reaction when separated from mothers for 3 to 4 months and disappeared after the mother came back. This severe depression is interpreted as a reaction to the loss of love object (mother), a reaction that brings about gross arrest of the infant's development and ultimately showing physical, intellectual and emotional retardation. It occurred with greater frequency and severity in cases where the mother infant relationship had been good prior to separation and no severe depression occurred where the relationship had been notably bad. This implies that it is more difficult to satisfy a love object, than an unsatisfactory one and that the greater the

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loss, the greater the readiness or likelihood for depressive reaction. Spitz's observation of excessive rocking, fecal play and other non oral autoerotism in institutionalised infants has been alluded to the above. There have been few criticisms about Spitz's study, that it was not a longitudinal study, that tests of infant development are not reliable and that babies from foundling homes were of inferior stock, etc.

Rie (1966) tried to explain from a dynamic point of view, why prepubertal children do not seem to have depressive illness. According to the dynamic concept of adult depression, a child cannot develop depression, because a person can have depression only after his superego is fully developed and only then can he feel guilt and act in a self punitive way.

While growth failure and impaired personality development occurring secondary to maternal deprivation have been stressed, Glasser (1967) believed that the existence of depressive elements in children often are not recognised and that too little attention is given to a corrective psychiatric approach to this problem. Glasser (1967) described depression in childhood as "masked" with such categories of symptoms as delinquency, school phobias and learning difficulties. Toolan (1962) notes that one of the reasons that suicidal attempts have been overlooked in children and adolescents is the erroneous concept that youngsters do not experience depression. It is true that they do not exhibit the classical signs and symptoms, but according to him depressive equivalents include a wide variety of symptomatology, e.g. psychosomatic symptoms, eating and sleeping disturbances, boredom, restlessness etc.

Among older children "acting out" and sociopathic manifestations are more likely to mask underlying depression. These may take the form of disobedience, temper tantrums, truancy or running away. School phobias or underachievement in school may characterise an underlying depression.

Hypochondriacal and psychosomatic problems camouflaging depression are most commonly seen in adults but they also occur in children and are relatively frequent in adolescents. In children they may take the form of headache, tics, choreiform movements, abdominal complaints, nausea, vomiting etc. Symptoms such as suicidal attempts, usually considered diagnostic of depression in adults are not necessarily indicative of depression in children but rather an example of impulsive anger or rebellion. Depression also may be masked among retarded children who in reality are often aware of their inadequacy. Such children are frequently rejected by their parents, sibling and peers. While their feelings of inadequacy and hopelessness may lead to overt depression, the depression may be masked under a blanket of irritability and rage outburst, directed towards authority figures. If this rage is stifled by punishment, it may be directed toward younger children, small animals or inanimate objects. Masked depressive reactions such as these are often misdiagnosed and mismanaged particularly in large institutions.

Puzanski and Zrull (1970) reviewed cases over a four year period and think that affective depression is seen clinically in children. In their review of 14 cases, the expression of an affective state of chronic unhappiness or sadness was essential to inclusion in the study. Other depressive symptomatology frequently seen were excessive crying, withdrawal and disturbed self image by the child (negative self image). Problems of handling aggression were extremely common and often expressed in episodic, violent outbursts. Their study of pathology demonstrated a high incidence of parental depression, difficulties in handling aggression and hostility and overt parental rejection. The authors re-evaluated 10 children, an average of 6½ years after they were described as affectively depressed. Mean age at follow up was 16.9 years. All 10 (8 boys and 2 girls) had psychopathology,

50% of them appeared clinically depressed at follow up. As this group approached adulthood, they tended to resemble adult depressives, supporting the idea that depression in childhood may persist and appear in its adult form. It also was evident that these young people had spontaneous remissions from depression. Neither broken homes nor parental loss were predictive of depression. At follow up all 10 had inadequate peer relationship. Dependency seemed more prominent in all, again resembling adult depression. Overt aggression was considerably reduced leaving these subjects with more evidence of passivity. Finally, performance and productivity of these subjects were very low and were uniformly low in depressed group at follow up.

There has been much confusion in diagnosing depression in children, because of the lack of agreement on definition of childhood depression and on childhood itself. Prevalence of childhood depression cannot be determined unless there is an agreement about the definition of childhood depression. In an epidemiological study of 2199 children between the ages of 10 and 11, Rutter *et al.* (1970) found that the rate of pure depression was low (only 0.1%). Rutter identified 3 groups of disturbed children, conduct disorder, emotional disorder and a mixed group of the above two. The disturbed ones had more depressive symptoms than the non disturbed ones.

Welner (1978) who wrote an overview on childhood depression, emphasised the fact that the criteria for childhood depression varied with each investigator. They are not based on clinical, family or follow up studies and as a result, the validity even the usefulness of these criteria is questionable. Their study of children of depressed parents showed that the clinical symptomatology of depression in children is very similar to that found in adults. Anthony and Scott (1960) suggested 10 criteria for diagnosis

of manic depressive psychosis in childhood and yet 3 out of 28 were diagnosed and even they only fulfilled five of his criteria. Weinberg *et al.* (1973) used the following criteria. Presence of both dysphoric mood and self deprecatory ideation as well as two or more of the following eight symptoms ; aggressive behaviour (agitation), sleep disturbance, diminished socialisation, change in attitude toward school, somatic complaints, change in school performance, loss of usual energy, unusual change in appetite or weight. Using these, he diagnosed 63% of children who were referred to an educational diagnostic centre for learning and behaviour problems. 19 were tried on anti-depressant medication and 3 to 7 months later, they were found to be much improved than the nontreated ones. A positive family history of an affective condition was present in 40 of the 45 depressed children. Depressed children had a high incidence of hyperactivity, school phobia, enuresis and other developmental behaviour problems occurring during the depressive period.

Frommer (1968) based the diagnosis of childhood depression on her clinical observation and response to treatment with anti-depressants. She identified 3 groups (1) the enuretic and encopretic depressive (also with antisocial problems) (2) pure depressive (3) phobic depressive. This study did not include a control group and is hence considered invalid. Also the use of anti-depressants in the treatment of enuresis is debatable. The mechanism of action is not known ; antidepressant action is not what produces the good result but possibly the effect of the drug on the bladder and on the phases of sleep. Cytryn and Mcknew (1972) say that depressive symptoms especially sad affect are very common in children. Most of the time, however, they are of short duration and do not interfere substantially with the child's functioning. In those where it is more severe, it does not usually manifest itself in a clearly recognisable form but rather presents as masked

depression. They may show a variety of emotional disorders, among them, hyperactivity, aggressive behaviour, psychosomatic illness, hypochondriasis and delinquency. In these cases the underlying depression is largely inferred from periodic display of a purely depressive picture and from depressive themes on projective tests such as the Rorschach and T. A. T. In addition to the many children with masked depression, Gytryn and Mcknew (1972) feel that there is a group of latency age children who present a clearly identifiable depressive syndromes. This syndrome includes a persistent sad affect, social withdrawal, hopelessness, psychomotor retardation, anxiety, school and social failure, sleep and feeding disturbance, suicidal ideas and threats but rarely attempts. They have classified childhood depression into three distinct categories (1) Masked depression is the most frequently appearing in children whose personality and family, display severe psychopathology (2) Acute depression—these children are fairly well adjusted prior to the traumatic event that precipitate the depression. There may be mild psychopathology in the family (3) chronically depressed children. They have a history of marginal premorbid social adjustment, depression and repeated separation from important adults and history of recurrent depression in at least one parent.

Gytryn and Mcknew in another article (1974) attempt to conceptualize a pattern of defence against depressive process that changes with age. They enumerate several forces that oppose and promote these defensive operations resulting in three levels of which the depressive process manifests itself; they are—fantasy, verbalisation, moods and behaviour. The shifting balance of these three forces helps to explain the variability with which the depressive process manifest throughout the various phases of the life cycle. (1) *Fantasy* as manifestation of depressive process, is demonstrated in dreams or spontaneous play or elicited by the use of projective tests, where de-

pressive themes viz., mistreatment, thwarting, blame or criticism, loss and abandonment, personal injury, death or suicide. (2) Verbal expression by spontaneous or elicited verbal content, talk of hopelessness, helplessness, guilt, of being unattractive, worthless, or unloved, plus suicidal preoccupations. (3) Mood and behaviour by manifestations of depressive affect that can be noticed without verbal exchange. These manifestations include psychomotor retardation, sadness, crying, disturbance in appetite and sleep and also such signs of masked depression as hyperactivity, aggressiveness, school failure, delinquency and psychosomatic symptoms. They try to explain the patterns of defences that help children to avoid experiencing or expressing depressive affect, at each level. In depressive fantasies, the defences are denial, projection, introjection, acting out and avoidance. This is most effective. Depressed verbalisation is less effective, the defences are dissociation of affect and reaction formation. In manifest depressive mood and behaviour, the defences seem to fail as in chronic and in some acute depressive reactions.

Pearce (1977) studied 547 children, between the age of 1 to 17 years, attending a child psychiatry department and found that 23% had symptoms of depression. He feels that no age is immune from depression but an infant requires unusually powerful adverse circumstances to acquire a depressive disorder. Increasing maturity reduced the threshold for depressive disorder and the threshold is still further reduced at puberty. Manic depressive psychosis is not seen until later in adolescence. Family influences are important in the development of childhood depressive disorder. The influence of cerebral biochemistry in the etiology of depressive effect in children is not known. There is no conclusive evidence that any treatment has a specific antidepressant effect. Treatment should emphasise the provision of optimal conditions at home and at school. This will often include treating

the parent's depression and working closely with the school. A depressive disorder can set up many new and often unhealthy patterns of behaviour and relationships and these may become self-perpetuating. Childhood depressive disorder should not be considered a transient phase of normal experience and development. Depressive disorder can occur in 10 to 20% of children attending a psychiatric clinic and without proper treatment the child's depression may have serious repercussions in adult life.

SUICIDAL TENDENCIES IN CHILDHOOD

There is not much written on suicide in children. According to Bender (1953) the child react to an unbearable situation with an attempt to escape. Mostly these unbearable situations consisted of deprivation of love, or at least the child assumed that the love was insufficient to meet his needs. The deprivation provoked aggressive tendencies which were primarily directed against those who denied love. Under the influence of feelings of guilt, these aggressive tendencies were turned against one's self. There was also a strong compulsive repetitive tendency to reenact aggressive behaviour observed in the parents. The suicidal attempt also constituted a punishment against the surroundings and a method to get greater amount of love. It also represented a reunion with the love object (always one of the parents). Melanie Klein (1948) also has discussed suicide in similar terms. In subsequent career of these children, who fantasied threatened and attempted suicide, it became progressively more evident that they were threatened by turmoil both from within themselves and their outside situations which became more difficult. But no suicide occurred for at least 14 years of follow up. They showed a tendency either to direct their aggression against the environment in antisocial and delinquent behaviour or they submitted to the intolerable situation, suffering emo-

tional and intellectual flattening and in many instances accepting refuge in institutions. In severe depression, children complain of outright depression possibly even suicidal ideas and feelings.

Literature on childhood depression in India is very scant. Although depressive symptoms are often included in the various neurotic groups, no separate diagnosis of depression is made—Venkoba Rao (1970) says in his article on "Broken homes and depressive illness", that psychological problems of the inmates of orphanages, beggar homes and destitute homes have been studied in India but depression does not appear to be a major problem among them. Manchanda and Manchanda (1978) found that among 49 neurotic children between the ages 6-12 years, 6.1% were depressed. Depression was 3rd in the order of frequency of neurosis, hysteria being most common (71.4%) and anxiety comes second (16.3%). They also found that neurotic disorders encountered were mostly in later childhood and were clinically similar to their counterpart in adults. Nandi *et al.* (1978) in their analysis of suicide in West Bengal found that 10-15% were under the age of 18 years. Whether these youngsters showed overt or masked depression is not mentioned. In our analysis of neurotic children seen at Vellore 7.8% had manifested masked depressive symptoms but none had overt symptoms of depression. The percentage of children showing masked and even overt symptoms of depression were found to be much higher in a child psychiatric clinic in Melbourne, Australia. Over 50% of these children there are put on antidepressants, for hyperactivity behaviour problem or enuresis, although, the use of antidepressants is questionable.

CONCLUSION

Depression in children and adolescents is often not recognised because it may be hidden in symptoms not readily identified with depression and these symptoms are

not necessarily found in adults with depressive illness. A review of the literatures on depressive illness in childhood indicates confusion in the basic concept of depression in childhood. The diagnosis of masked depression is given to children with a wide range of different problems, based on the hypothesis that depression in childhood can be manifested by clinical symptomatology quite distinct from that found in adults. There is no general agreement on criteria for childhood depression. The diagnosis of depression in childhood is being based on clinical impression, arbitrarily selected criteria or on a favourable response to treatment with antidepressants. If symptoms in childhood such as antisocial behaviour, neurosis and others are signs of underlying depression it is important to understand them accordingly and treat them appropriately.

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