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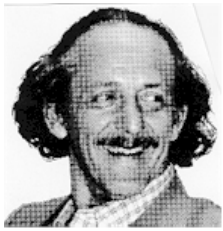

Current Comments

What Do We Know about Depression? Part 3: Children and Adolescents

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This is the last of a three part series on depression. Part one examined the etiology of depression and some conceptual models that are currently generating a lot of literature.[1] Part two discussed diagnosis and treatment.[2] This essay will focus on depressive disorders among the young, particularly adolescents.

It is difficult to discuss the literature on adolescent depression without saying something about depression in children. Now that there is a growing consensus that children as young as five years old, and perhaps even infants, can suffer depression,[3] many authors overlap their discussions of adolescent and childhood depression.

Interest in depressive disorders among people under 18 years old is very new. In fact, as Gerald Klerman, Harvard School of Medicine, and others have pointed out, adolescence as a developmental phase is a 20th-century invention. "Whereas puberty is a biological event," writes Klerman, "adolescence is a social phenomenon that did not merit attention until World War II."[4]

In trying to determine how many adolescents are depressed, one encounters the same difficulties as in trying to count depressives in the general population. As I noted in part one, disagreement within the professional community over just what constitutes clinical depression, and a number of methodological problems, frustrate attempts to arrive at precise and reliable figures.[5]

Most epidemiological studies agree that depression is primarily an adult disorder.[5-7] In general, the incidence of depression rises with age. People over age 65 may have a higher incidence than any other age group.[8] I have discussed some aspects of depression in the elderly in a previous essay.[9] In his overview of adolescent depression, Irving B. Weiner, Case Western Reserve University, reported that nearly 13 percent of a sample of depressive outpatients were under the age of 19. Among adolescents, the incidence of depression rises with age. Of the sample reported by Weiner, 1.7 percent were between the ages of ten and 14. This number nearly doubled to 3.3 percent for the age group 15 to 17. The incidence doubled again to 7.6 percent for people aged 18 and 19.[10] But Weiner acknowledges that depression is generally underdiagnosed in young people, a problem that I will discuss below.

As in the adult population, female adolescents suffer depression more than their male counterparts. Most authorities regard the preponderance of female depressives as real, and not due to statistical artifacts.[11] In the study reported by Weiner, female depressives outnumber males by about two to one in the 15 to 17 age group.[10]

As is true for all age groups,[12] more adolescents are being diagnosed as

depressed than ever before. This is undoubtedly due to better diagnostic techniques and increased awareness that young people can become depressed. But Klerman, for one, believes that the increase is at least partly due to a real increase in incidence.[4] What is certain is that the incidence of adolescent suicides has been rising steadily in the last half of this century, faster than any other age group. A recent review in the journal *Child Welfare* reported some truly alarming statistics.[13] Between the years 1954 and 1973, the rate for suicides among people aged 15 to 19 jumped from 2.4 per 100,000 to seven per 100,000. Suicide is now the second leading cause of death among people ten to 20 years old.[14]

More alarming than these statistics is the consensus among nearly all authors who discuss adolescent suicide that the true incidence is grossly underreported. Many suicides are mislabeled as accidents. Anne Somers, Rutgers Medical School, New Jersey, reported in the *New England Journal of Medicine* that perhaps 15 percent of all automobile accident fatalities are actually suicides.[15] And the Suicide Prevention Center of Los Angeles estimates that perhaps 50 percent of all suicides are disguised as accidents.[16]

Although females outnumber males in incidence of depression, males greatly outnumber females in suicides. This is true for adolescents as well as for the general population. But in all age groups, females by far outnumber males in suicide *attempts*.[16]

One very disturbing aspect of adolescent suicide is that those who attempt it rarely give people around them any obvious indication of their intentions. An adolescent suicide often appears to be a sudden and impulsive reaction to such stresses as the breakup of a romance or a quarrel with parents.[16] This impulsiveness was dramatically demonstrated late in the 18th century in Europe. The great German writer Goethe wrote a romantic novel in which the hero, the young Werther, committed suicide over lost love. The publication of this novel in 1774 touched off a veritable epidemic of suicides among the young people of Europe.[17] The impulsive nature of adolescent suicide has prompted James Toolan, University of Vermont School of Medicine, to write: "Every youngster who attempts or seriously threatens suicide should have a thorough psychiatric evaluation."[16]

Until recently, and perhaps still, depression has been consistently underdiagnosed in adolescents.[10] One reason is the uncertainty over just what constitutes depressive behavior in youngsters. For years, the prevailing view has been that normal adolescence is a time of turmoil characterized by wild swings in mood. Therefore, the boundary between normal adolescent behavior and psychopathology is difficult to determine. While this view was prevalent, many disturbed adolescents were diagnosed as suffering "adjustment reactions." Treatment consisted mainly of forbearance and the hope that the "problem child" would soon "grow out of it."[18]

Although many still hold the view that normal adolescence is a time of psychological turmoil,[19] there has lately been a marked shift in viewpoint among researchers and clinicians. Many now believe that normal adolescents are no more unstable than normal adults. Thus, adolescents who exhibit symptoms of depressive disorder may indeed have one.[10] This belief has prompted the hope that the diagnosis of "adjustment reaction" could be abandoned.[20] For example, Kayoumars Fard and colleagues, Washington University School of Medicine, St. Louis, assert that adjustment reaction is "used in such a vague and all-encompassing manner as

to be useless."[21] But last year, when the American Psychiatric Association updated its *Diagnostic and Statistical Manual of Mental Disorders* for the first time since 1968, adjustment disorder was retained as a diagnostic classification.[22]

The literature on depression in adolescents and children contains a number of discussions of "masked depression." In part one, I mentioned this phenomenon in which people supposedly suffer depression without exhibiting the usual symptoms. Alcohol or drug abuse, psychosomatic complaints, or hypochondria disguise the underlying disorder. Its existence among adolescents is predicated on the hypothesis that since they are going through a different stage of development than adults, the manifestations of depressive illness could very well differ from that of adults.[23]

In 1962, Toolan wrote that in many youngsters, such conduct disorders as delinquency, hyperactivity, or aggression may mask a depression. More precisely, they represent an "equivalent disorder."[23] This idea had a significant impact on adolescent and child psychiatry for many years. Even today, the concept of equivalent disorder has by no means been entirely abandoned. Last year, for example, John A. Chiles and colleagues, University of Washington School of Medicine, Seattle, found that among a sample population of 13 to 15 year olds in a correctional institution for delinquents, 23 percent met criteria for depression. Of their findings, the authors commented: "These data do not support the depressive equivalent hypothesis, but neither does it [sic] refute it."[24]

Nevertheless, a number of researchers and practitioners have recently moved away from the idea that nondepressive symptoms can fully disguise an underlying depression. They believe that although some symptoms may be peculiar to adolescents, young people can generally be diagnosed according to the same criteria that are applied to adults. As Gabrielle Carlson and Dennis Cantwell, UCLA School of Medicine, put it, "Although children with a depressive disorder may also exhibit behavior disorders that overshadow the depression, an alert clinician conducting a thorough interview should be able to identify the 'masked' depression."[25]

In 1979, Ada C. Mezzich, Ohio State University, and Juan E. Mezzich, Stanford University, listed the symptoms of adolescent depression according to the frequency with which they are reported in the literature. The most frequent symptoms are sadness, hypochondriacal complaints, suicide ideation, hopelessness, guilt feelings, and anxiety. All of these symptoms can be found in adult depression. But interestingly, aggression ranks seventh on the Mezzichs' list of symptoms.[20] This contrasts sharply with adult depression, in which aggression is often lacking.[26]

While depression was previously rarely diagnosed in adolescents, it was almost never diagnosed in children. Until recently, textbooks on childhood psychiatry had little to say about depression.[27] It was commonly held that the lack of future orientation in children, their preoccupation with the "here and now," made the possibility of self-perpetuating clinical depression unlikely.[28] But now there is increasing recognition that even very young children can suffer depression. In 1975, the National Institute of Mental Health convened a conference on childhood depression in Washington, DC. The proceedings of the conference, published two years later, still serves as a good primer on the subject.[3] Incidentally, depression in teenagers was one topic discussed at the 1981 National Conference of Big Brothers/Big Sisters of America, held in Philadelphia on June 16-20.

Despite increased awareness of depression in children and adolescents, there may still be a tendency to underdiagnose these age groups. As I mentioned in part one, a subjective feeling of depression or sadness is one of the major symptoms of depression. Yet, as Margaret Hertzig, New York Hospital's Payne Whitney Psychiatric Clinic, points out, subjective depression is rarely reported by children and adolescents: "It's not a case where they tell their parents they're depressed, and the parents in turn tell the psychiatrist. Often, it's the parent or the teacher who makes the presenting complaint of 'disturbed behavior.' "[29]

Treatment for adolescent depression closely resembles that for adults. A combination of drugs and psychotherapy is commonly used. Tricyclic medication, which I described in part two, is prescribed as readily for adolescents as for adults. Administering psychotherapy is sometimes a problem, however. Since the young person needs activity, it is often difficult to hold adolescents in a long-term psychotherapeutic relationship.[29] According to Hertzig, a goal of psychotherapy with adolescents is to give them a positive experience over a short term. Such therapy can also be conceived as a preparation for later treatment in case there should be a recrudescence of old problems or the appearance of new ones.[29]

A recent series of studies by Joaquim Puig-Antich[30,31] and colleagues, New York State Psychiatric Institute, indicate that so-called "endogenous" depression, depressions that are biochemical in origin, can occur even in prepubertal children. The studies show that the same diagnostic techniques used for adults, such as the Dexamethasone Suppression Test (DST), described in part two, can be useful in identifying such depressions.[30] The studies further indicate the possible effectiveness of tricyclics for young children.[31] More recently, separate research teams headed by Elva O. Poznanski, University of Illinois at Chicago, and Douglas R. Robbins, University of Michigan, reported some success in using the DST to diagnose depression in age groups six to 12, and 12 to 18 respectively.[32] Their as yet unpublished findings, reported in *Science News,* were presented to a meeting of the American Psychiatric Association this year in New Orleans.

Bipolar disorder, or manic-depression, is uncommon in adolescents and even rarer in children.[33] Nevertheless, there has been an increasing number of individual case reports of bipolar disorder in the young. It may well be that, at present, manic-depression is seriously underdiagnosed in adolescents. In about one third of the cases, the onset of manic-depression occurs in late adolescence.[34] And manic-depression is more strongly associated with suicide than depression alone, asserts Kay R. Jamison, director, UCLA's Affective Disorders Clinic. "Student health centers don't look at manic-depression seriously enough," says Jamison, "and it's tragic because the illness is not too difficult to diagnose and it's very treatable."[35]

As with adults, young manic-depressives are treated with lithium. However, in a recent letter to the *American Journal of Psychiatry*, two physicians reported the case of a 17-year-old boy on lithium treatment who developed gastric ulcers.[36] The ulcers did not respond to cimetidine and did not go away until lithium was discontinued. The physicians call for more research to see if the side effects of lithium are more acute for adolescents.[36]

Why do adolescents get depressed? The literature offers many reasons. Irving Ringdahl, University of Arkansas Medical Center, views adolescent de-

pression as a consequence of development. "The dramatic physiologic changes that begin to appear at puberty," he writes, "coupled with society's demand for adult behavior, may threaten the adolescent's emotional mechanisms and produce a state of turmoil."[19]

Klerman thinks social factors contribute to a rise in adolescent depression. "In a highly individualistic society," he writes, "periods such as youth and adolescence are characterized by rising expectations for personal achievement.... Yet the likelihood of these being realized may well decrease as our society adapts to shrinking natural resources, energy reserves, and overpopulation."[4]

Other researchers look to the family environment for an answer. Some feel that the pressure of parental expectations might result in depression among adolescents.[37] Perhaps this explains the finding that one in six college students is "depressed" at any given time.[38] Still, little is known about the influence of family life on the psychological health of adolescents. As J. Conrad Schwarz, University of Connecticut, and David C. Zuroff, Quinnipiac College, Connecticut, wrote in the *Journal of Abnormal Psychology*, "Despite the conviction of most clinicians that the family plays a crucial role in the development of psychopathology, empirical research has frequently found nonsignificant or inconsistent relations between family variables and pathology."[39]

Several authors write of the "alienation of youth" as an etiological factor in adolescent depression. Yet in their overview of research into adolescent suicides, Jacquelin Greuling and Richard DeBlassie, New Mexico State University, note that during the time of campus unrest in the late 1960s and early 1970s, the rate of student suicides was lower than for nonstudent young people. Moreover, those students who were actively engaged in "fighting the establishment" experienced fewer suicides than their nonactivist peers on campus.[14]

Several studies have correlated drug and alcohol abuse and other life threatening behaviors with depression.[40,41] However, most authors regard these behaviors as results of, and not the causes of, depression. A recent study by Stuart Kaplan and colleagues, Long Island Jewish-Hillside Medical Center, confirmed this correlation and offered the following speculation: "Smoking and overeating are socially acceptable forms of suicide. They are self-destructive, but culturally sanctioned."[41]

While scientists have recently shifted some focus to adolescent depression, the tragedy of this disorder remains unabated. Relatives and friends of a depressed young person feel a sense of helplessness in the face of such an illusive illness. Clearly more research needs to be undertaken to find out the causes and cures of adolescent depression.

Apart from the fact that the literature on the subject of depression is vast, even overwhelming, readers may wonder why I have devoted so much attention to this problem. I have told you about its high incidence and the need for and opportunity for research breakthroughs. But the subject has a particularly painful and personal meaning for me. Just one year ago, my daughter Thea committed suicide. I have tried to reflect upon her tragedy in a less personal way by examining what we do know about suicidal adolescents. In doing this, I may have failed to provide a loud and clear message to those who may find themselves in a similar situation. When a child is suffering a suicidal depression, parents and loved ones are oftentimes the least able to perceive the clear and present danger. As is so often the case, adolescent patients are ex-

tremely clever in deceiving loved ones into thinking everything is all right. The tragedy of Thea's death was compounded because there were incredible human and technological failures in communication.

If there is any advice to offer my readers, it is this: never trust your own judgment or that of your child. Be sure that you have taken advantage of the best professional advice available to confirm that your usually optimistic judgment isn't wishful thinking.

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