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## Editorials

### Depression in children

#### *May go unnoticed and untreated*

Children with depressive disorders lack interest in activities they previously enjoyed, criticise themselves, and are pessimistic or hopeless about the future. They may feel sad or irritable. Problems at school arise from indecision and difficulties with concentration. Depressed children tend to lack energy and have problems sleeping. They may have stomach aches or headaches. Morbid thoughts may progress to suicidal thinking and even suicide attempts.<sup>1</sup> For various reasons, some adults find it hard to accept that children may experience unpleasant psychological states such as depression. Compared with the literature on depression in adults, evidence from randomised controlled trials for the efficacy of treatments for depression in young people is scarce.

A community survey of Australian children found that 3.7% of boys and 2.1% of girls aged 6-12 years had experienced a depressive episode in the previous 12 months.<sup>2</sup> The average duration of a depressive episode in young people is about nine months, with a 70% probability of relapse within five years.<sup>3</sup> Evidence shows continuity between childhood depression and depression experienced in adulthood, with the phenomenology becoming more "adult-like" as the child progresses through adolescence.<sup>3</sup> Depression in children usually arises from a combination of genetic vulnerability, suboptimal early developmental experiences, and exposure to stresses. But depressive syndromes sometimes occur as sequelae to physical illness such as viral infection and may overlap with fatigue syndromes.<sup>4</sup>

Doctors encounter depressed children through their presentation with somatic complaints or suicidal behaviour; such children come to the attention of school welfare staff because of non-attendance at school, academic decline, or disruptive behaviour. Many depressed children, however, suffer in silence. Symptoms may go unnoticed because of a tendency for depression to have an insidious onset in children, and because the symptoms may fluctuate in intensity. Children have less of a role burden than adults do, hence impairment may be less apparent. In addition, depressive symptoms may be confounded by comorbid conditions such as conduct disorder and hyperactivity.<sup>2</sup> A suspicion of depression in a child demands direct interview and observation of the child, in addition to the information obtained from parents and teachers. Even quite young children can respond to structured questions about depression.<sup>1</sup>

Rigorous evidence for the efficacy of treatments for depression in young people is scarce. To make matters worse, few trials separate out data from children and adolescents. This is important because children may have a different response to treatment than adolescents and adults.<sup>5</sup> Although trials have examined the efficacy of several forms of psychotherapy for depression in adolescents, only trials of cognitive behaviour therapy have included prepubertal children.<sup>6</sup> One systematic review (of six randomised controlled trials of which two included prepubertal children; 376 people) found cognitive behaviour therapy superior to other therapies, which ranged from control of waiting lists to supportive psychotherapy in resolving symptoms of depression.<sup>7</sup> Although cognitive behaviour therapy is a promising treatment, its application is limited by the number of available practitioners; few general practitioners have the necessary training. Cognitive behaviour therapy may prove most useful as a preventive measure against depression. A randomised controlled trial of cognitive behaviour therapy directed to adolescents with subclinical depression showed effectiveness in lowering the subsequent incidence of depressive

disorder.<sup>8</sup> Similar studies have been proposed for children of primary school age.

Evidence for the efficacy of pharmacological treatment is also limited. A Cochrane review of tricyclic antidepressants identified three trials including a total of 65 prepubertal children. A statistically non-significant trend favouring placebo over active treatment was found.<sup>5</sup> Since the side effects of tricyclic drugs are potentially serious, their risks clearly outweigh the benefits. One randomised controlled trial of lithium versus placebo (n=30, age 6-12 years with depression and family history of bipolar affective disorder) found no significant difference in global assessment or depression scores. Of the newer antidepressant drugs widely studied in adults, only trials of fluoxetine (n=96, age 7-17) and moclobemide (n=20, age 9 to 15) have included prepubertal children.<sup>9 10</sup> Both trials found significant differences between active treatment and placebo in clinicians' ratings of global improvement. Reports by parents or patients themselves did not differ between the groups.

Since 1998 the Food and Drug Administration in the United States has taken steps to stimulate pharmacological research in children, resulting in a notable increase in the number and quality of controlled trials of psychotropic drugs in the paediatric population. In response there has been a wave of sentiment against the use of medication to treat depression in children.<sup>11</sup> Children are less likely than adults to receive adequate analgesia for physical pain.<sup>12</sup> There is a danger that, because of limited research and some antagonism to drug treatment, the same thing may happen with depression.

**Philip Hazell, professor.**

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