Education and debate

Rethinking childhood depression

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Unhappiness among children seems to be rising, but labelling it as depression and prescribing antidepressants is ineffective and possibly harmful. It is time to focus on the underlying reasons

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Increasing numbers of children are being treated for depression. At the end of 2003, over 50 000 children were prescribed antidepressants, and over 170 000 prescriptions a year for antidepressants were issued to people under 18 years old in the United Kingdom.¹ Recent evidence has suggested that selective serotonin reuptake inhibitors are largely ineffective and may be dangerous in this age group.²⁻³ Older antidepressants have already been shown to have no beneficial effect in people under 18.⁴ So how did we get into this mess? Undoubtedly part of the problem is with pharmaceutical industry tactics, designed to enable greater consumption of their products.³ However, the gateway diagnosis to prescribing antidepressants to under 18s is that of childhood depression. In this article I discuss the notion of childhood depression and suggest that the medicalisation of children's unhappiness is hindering our ability to respond effectively to this problem.

Meaning of childhood

Western society's ideas about childhood and child rearing have changed radically in the past 60 years. The West's attitude to child rearing changed from viewing relations between adults and children primarily in terms of discipline and authority to a focus on permissiveness and individual rights.⁵ In addition, whereas the model used before the second world war prepared children for the workplace within a society of scarcity, the post-war model prepared them to become pleasure seeking consumers (along with their parents) within a prosperous new economy.⁶

Shifting economic structures also led to profound changes in the organisation of family life. Suburbanisation and the economic demands of successful market economies resulted in greater mobility, less time for family life, and a breakdown of the extended family. Many families (particularly those headed by young women) became isolated from traditional sources of childrearing information. Guides on childrearing took on an unprecedented importance, allowing for a greater change in parenting styles than would have been conceivable in more rooted communities and giving professionals increased ownership of the knowledge base for the task of parenting.⁷

The new child centred permissive culture was a godsend to consumer capitalism. Childhood could now be commercialised, and an industry of consumer

Changes in organisation of family life are contributing to childhood unhappiness

goods for children developed.⁸ As a result, children have gained access to the world of adult information and entertainment. The boundaries between what is considered adulthood and what is considered childhood have become blurred, and this has led to children coming to be viewed as, in effect, miniature adults.⁹ One effect of these changing expectations of childhood and parenting is that more childhood behaviours previously considered normal are now seen as problematic, and problematic behaviours are more likely to be medicalised.¹⁰

Childhood depression

Just as our concepts of childhood have changed, so have our concepts of childhood problems. It was only in the late 1980s that our understanding of childhood depression began a far reaching transformation. Before this, childhood depression was viewed as very rare, different from adult depression, and not amenable to treatment with antidepressants.¹¹ A shift in theory, and consequently practice, then took place as influential academics claimed that childhood depression was more common than previously thought (8-20% of children and adolescents), resembled adult depression, and was amenable to treatment with antidepressants (often resulting in antidepressants becoming a first line treatment^{3,4,12}).

Childhood depression has become a popular notion, reflecting the broader cultural changes that have taken place in our view of childhood and its problems. These days we are as likely to use medicalised terminology to describe children's feelings

(such as depressed) as we are less pathological descriptions (such as unhappy).

How good is the scientific evidence?

According to the current criteria, psychiatric comorbidity in childhood depression is so high that nearly every child can be diagnosed with at least one other psychiatric condition.⁴ This raises doubts over the specificity of the construct. Despite awareness of the continuity between normal sadness and clinical depression, the diagnosis assumes that clinical depression exists as a category (rather than on a continuum). It is unclear, however, who decides where the cut-off mark is, and on what basis.

Furthermore, the categorical diagnosis bears only a tenuous relation with levels of psychosocial impairment. Many children below the threshold of diagnosis show higher levels of impairment than those above the threshold.¹³ Similarly, a diagnosis of childhood depression is only weakly associated with suicide (stronger predictors include history of aggression and use of drugs or alcohol).¹⁴ The biological markers (such as cortisol hypersecretion) that are sometimes found in adults diagnosed with depression do not work with children and adolescents diagnosed as depressed.⁴ With regard to genetics, separating environmental from biological factors in the familial clustering has been virtually impossible, particularly as children whose parents have depression are at risk of developing a wide range of psychiatric disorders.¹⁴

Childhood depression has been argued to be a precursor of adulthood depression.¹⁵ However, follow up studies of children deemed to have had "major depressive disorders" have used dubious standards for diagnosing childhood and adult psychiatric disorders, have discovered high rates of comorbidity (in childhood and adulthood), have been unable to differentiate biological factors from continuing social adversity,^{15 16} and have not taken into account the possible effects of any treatment received (such as continuing morbidity as a result of toxic side effects of drug treatment and the experience of psychosocial adversity and decreased self worth arising from becoming a psychiatric patient).

Leading researchers claim that childhood depression resembles adult depression.⁴ However, based on symptoms alone, children do not show many of the symptoms said to be common in adult depression (such as loss of weight and appetite, sleep disturbance, and feelings of guilt). Instead more non-specific symptoms such as irritability, running away from home, decline in schoolwork, and headaches are described as indicative of childhood depression.¹⁷

Utility of childhood depression in treatment decisions

The problem with context deprived notions of childhood problems is that they lead to context deprived, often medicalised, solutions of dubious value that may carry considerable risks. The increase in rates of childhood depression in Western society¹⁸ may reflect a lowering of the threshold for the diagnosis arising from a change in the meaning we give to childhood unhappiness. However, there may also be a

Summary points

Childhood depression is the gateway diagnosis for prescribing antidepressants to under 18 year olds

Changes in Western cultural beliefs have resulted in more childhood behaviours being viewed as a medical problem

Childhood depression as a categorical diagnosis cannot be differentiated from normal unhappiness

As well as changing the meaning given to childhood problems, sociocultural change has probably caused increasing unhappiness in young people

A multiperspective approach is needed to deal with children's unhappiness with more emphasis on non-medical treatment

genuine increase in the amount of unhappiness experienced by children as a result of growing up in a cultural context that has seen huge changes in child rearing practices, family structures, lifestyles, and education. Changes in Western economies, working practices in competitive global markets, and capitalism's need for never ending growth mean that more parents feel forced to work for longer hours. State support for children and families has been cut (particularly in the 1980s and 1990s), resulting in widespread child poverty. With the increase in the number of divorces and two working parents, fathers and mothers are around their children for less of the day, contributing to a generation of "home aloners": children who have largely to raise themselves.¹⁹

Much evidence suggests that children and adolescents in the West experience greater mental health problems as a result of these sociocultural changes. In the second half of the last century, rates of psychosocial problems (such as crime, suicidal behaviour, anxiety, unhappiness, and substance abuse) increased sharply among children and adolescents in Western societies.¹⁸ Understanding the impact of these adverse social changes is likely to be vital in helping us develop appropriate interventions for unhappy children. For example, an increase in family decay (from factors such as divorce rates) is associated with increases in youth violence, substance misuse, and suicide.²⁰ Context deprived models, such as childhood depression, that conceptualise problems in individualistic terms and therefore lead to individualistic interventions (such as pharmacotherapy and cognitive therapy) push more context rich interventions (such as systemic ones) to the margins.

We need a multiperspective approach to both assessment and treatment of unhappy children and their families. Such an approach should normalise emotional responses to adverse life experiences, emphasise more positive approaches (such as building on existing strengths and resilience), and engage more

systemic biopsychosocial interventions (including biological factors such as diet, exercise, and cognitive abilities).¹⁰ Medical researchers need to develop a more creative dialogue with researchers from other disciplines (such as sociology) to integrate within-body perspectives with broader ones. Childhood depression as an individualised, context depleted label that offers little explanatory power and can marginalise more helpful, context rich explanations, may first need to be abandoned before more comprehensive theory and practice with regard to children's unhappiness can emerge.

Contributors and sources: ST studies and writes articles and books on social, cultural, and political aspects of children's mental health. The idea for this article first developed after ST wrote a response, on behalf of the Critical Psychiatry Network, to the National Institute of Clinical Excellence on the subject of treatment for childhood depression.

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- 1 Boseley S. 50 000 children taking antidepressants. *Guardian* 2003 Sep 20:1.
- 2 Ramchandani P. Treatment of major depressive disorder in children and adolescents. *BMJ* 2004;328:3-4.
- 3 Jureidini J, Doecke C, Mansfield PR, Haby M, Menkes DB, Tonkin A. Efficacy and safety of antidepressants for children and adolescents. *BMJ* 2004;328:879-83.
- 4 Harrington R. Affective disorders. In: Rutter M, Taylor E, Hersov L, eds. *Child and adolescent psychiatry, modern approaches*. 3rd ed. Oxford: Blackwell Scientific, 1994.

- 5 Jenkins H. Childhood innocence and other modern myths. In: *Children's culture reader*. New York: New York University Press, 1998:1-37.
- 6 Wolfenstein M. Fun morality: an analysis of recent child-training literature. In: Mead M, Wolfenstein M, eds. *Childhood in contemporary cultures*. Chicago: University of Chicago Press, 1955:168-78.
- 7 Zuckerman M. Dr Spock: the confidence man. In: Rosenberg C, ed. *The family in history*. Philadelphia: University of Pennsylvania Press, 1975: 179-207.
- 8 Weinman-Lear M. *The child worshipers*. New York: Pocket, 1963.
- 9 Jenhs C. *Childhood*. London: Routledge, 1996.
- 10 Timimi S. *Pathological child psychiatry and the medicalization of childhood*. London: Brunner-Routledge, 2002.
- 11 Gelder M, Gath D, Mayou R. *Oxford textbook of psychiatry*. 2nd ed. Oxford: Oxford University Press, 1989.
- 12 Reynolds WM, Johnston HF. *Handbook of depression in children and adolescents*. New York: Plenum Press, 1994.
- 13 Pickles A, Rowe R, Simonoff E, Foley D, Rutter M, Silberg J. Child psychiatric symptoms and psychosocial impairment: relationship and prognostic significance. *Br J Psychiatry* 2001;179:230-53.
- 14 Wickes-Nelson R, Israel A. *Behaviour disorders of childhood*. London: Pearson Higher Education, 2002.
- 15 Harrington R, Fudge H, Rutter M, Bredenkamp C, Groothues C, Pridham J. Child and adult depression: a test of continuities with data from a family study. *Br J Psychiatry* 1993;162:627-33.
- 16 Fombonne E, Wostear G, Cooper V, Harrington R, Rutter M. The Maudsley long-term follow-up of child and adolescent depression I. Psychiatric outcomes in adulthood. *Br J Psychiatry* 2001;179:210-7.
- 17 Hill P. Child and adolescent psychiatry. In: Murray R, Hill P, McGuffin P, eds. *The essentials of postgraduate psychiatry*. 3rd ed. Cambridge: Cambridge University Press, 1997:97-143.
- 18 Rutter M, Smith D. *Psychosocial disorders in the young: time trends and their causes*. Chichester: John Wiley, 1995.
- 19 Kincheloe J. The new childhood; Home alone as a way of life. In: Jenkins H, ed. *Children's culture reader*. New York: New York University Press, 1998:159-77.
- 20 Pampel F, Williamson J. Age patterns of suicide and homicide mortality rates in high-income nations. *Social Forces* 2001;80:251-82.

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Commentary: abandoning the diagnosis will endanger severely depressed children

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As a family therapist, I applaud Timimi's broadly systemic approach to childhood unhappiness.¹ In my experience, young people aged 14-16 are most likely to present to clinicians with depression, and he is right to emphasise the sociocultural roots of their unhappiness. However, I am concerned at the underemphasis on possible consequences of depression, such as school failure, social withdrawal, antisocial behaviour, substance misuse, family disharmony, and suicide, which are more than just potential comorbidities.

I agree that psychoeducation is an important component of treatment. This includes acknowledging that some life experiences can be more difficult than others, particularly losses; that sleep can be improved by exercise; that mood can be improved by activity scheduling; and that an emphasis on the positive is more likely to help than a focus on the negative. But I cannot see that this is enough; nor do I think that child mental health professionals can in general change the contexts that contribute to adolescent depression, such as schools that pressurise, parents who are too busy, or friends who are unsupportive. Is it enough to refer such young people to psychologists or psychotherapists?

The idea that the symptoms of depression in children are different from those in adults is not new. But this does not mean that treatments have to be different. On the contrary, available evidence suggests that those treatments effective for adults are also effective for adolescents.²⁻³ Despite the debate about suicidal

ideation with some antidepressants, a consensus seems to have emerged that fluoxetine is both effective and safe.⁴

The danger of abandoning the diagnosis of depressive disorder is that the evidence base for effective psychological and pharmacological treatments may also be disregarded. Just because depression is on a continuum with unhappiness is hardly a reason for not setting a cut-off point for treatment. Applying the same argument to blood pressure could lead to an epidemic of preventable strokes and renal disease. Child psychiatrists who treat adolescents with severe depression know that both psychological therapies and antidepressants work: the more severe the depression, the more likely are the benefits to outweigh the risks.

Competing interests: QS has accepted invitations from Janssen-Cilag and Eli Lilly to attend meetings about attention deficit hyperactivity disorder.

- 1 Timimi S. Rethinking childhood depression. *BMJ* 2004;329:1394-6.
- 2 March J, Silva S, Petrycki S, Curry J, Wells K, Fairbank J, et al. Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: treatment for adolescents with depression study (TADS) randomized controlled trial. *JAMA* 2004;292:807-20.
- 3 Mufson L, Dorta KP, Wickramaratne P, Nomura Y, Olsson M, Myrna M. A randomized effectiveness trial of interpersonal psychotherapy for depressed adolescents. *Arch Gen Psychiatry* 2004;61:577-84.
- 4 Whittington CJ, Kendall T, Fonagy P, Cottrell D, Cotgrove A, Boddington E. Selective serotonin reuptake inhibitors in childhood depression: systematic review of published versus unpublished data. *Lancet* 2004;363:1341-5.