Commentary: a controversy too far?

Paul Wilkinson

The use of antidepressants in depressed children (here referring to both children and adolescents) is controversial. Timimi takes this issue further by questioning the validity of the diagnosis of depression in childhood.¹ Here the author is out of step with what is known.

Epidemiological studies using reliable psychiatric methods have established beyond doubt that the full range of depressive symptoms are present in representative samples of children. It is true that there is a spectrum of depressive disorders, with an arbitrary cut-off point of five symptoms for the diagnosis of unipolar major depression in DSM-IV and ICD-10. However, children with this major depression (diagnosed by standardised psychiatric interviews) do have specifically increased risk of adulthood depression compared with children with non-affective psychiatric disorders and well controls.² Furthermore, children with clinical depression are more impaired than unhappy children with fewer symptoms.³ From the physiological perspective, raised concentrations of the steroid hormones cortisol and dehydroepiandrosterone distinguish depressed from non-depressed psychiatrically unwell children and well controls; predict the subsequent onset of depression in well children; and also determine the persistence of an episode of childhood depression lasting longer than two years better than psychosocial factors.^{4,5}

Importantly, we know that young people with this diagnosis are more likely to recover if they receive treatment than if they do not. Studies have shown substantial differences between treatment control and groups with fluoxetine,⁶ cognitive behaviour therapy (particularly in combination with fluoxetine),⁶ and interpersonal therapy.

Future diagnosis

The diagnosis is not perfect. In particular, great comorbidity exists with other psychiatric conditions. But to say that the diagnosis is invalid because of clinical complexity is at best incorrect and at worst potentially misleading to patients and doctors. Research suggests that there are several subtypes of

depression. Whether these will respond differently to specific treatments or have different biological correlates needs further research.

In the future, the term depression may be replaced by several diagnoses, differentiated scientifically by comorbidity, hormonal markers, or genetic variation. These biological as well as psychosocial factors may be important in determining risk of onset, response to treatment, and prognosis. A broader diagnosis of emotional disorder may also be established, encompassing certain depressive and anxiety conditions that share a similar aetiology and treatment response. Currently, however, the evidence is overwhelming that children and adolescents with depression should be grouped together and distinguished from those with non-depressive psychiatric disorders.

Advances in our understanding of the scientific basis of depression in young people are no signal to ignore psychosocial issues. These must always be fully assessed and addressed, in every depressed patient. There should be no reflex reaction of reaching for the prescription pad. But though it is wrong to neglect psychosocial treatments, it is equally unacceptable to neglect evidence based pharmacological treatments for those who may truly benefit and recover from a mental disorder that carries serious risks for recurrence into adult life.

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- 1 Timimi S. Rethinking childhood depression. *BMJ* 2004;329:1394-6.
- 2 Lewinsohn PM, Rohde P, Klein DN, Seeley JR. Natural course of adolescent major depressive disorder: I. Continuity into young adulthood. *J Am Acad Child Adolesc Psychiatry* 1999;38:56-63.
- 3 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;179:230-5.
- 4 Goodyer IM, Park RJ, Netherton CM, Herbert J. Possible role of cortisol and dehydroepiandrosterone in human development and psychopathology. *Br J Psychiatry* 2001;179:243-9.
- 5 Goodyer IM, Herbert J, Tamplin A. Psychoendocrine antecedents of persistent first-episode major depression in adolescents: a community-based longitudinal enquiry. *Psychol Med* 2003;33:601-10.
- 6 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.

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