Status of diagnosis of childhood depression

Kay L. Erland

University of Northern Iowa

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Abstract
Affective disorders in children were not recognized by professional clinicians until the beginning of the twentieth century. It was 1960 before a major textbook of psychiatry included a chapter on childhood depression (Cytryn & McKnew, 1979). To many, the idea of a child being depressed is contrary to images of childhood as a happy, carefree time (Lasko, 1986). Yet, children do show unhappy feelings in many different ways as they mature from infancy to adolescence (Epanchin, 1987). It has been estimated that 20% of the school-age population have some symptoms of depression at some time (Epstein & Cullinan, 1986).
STATUS OF DIAGNOSIS OF CHILDHOOD DEPRESSION

A Research Paper
Presented to
The Department of Educational Administration
and Counseling
University of Northern Iowa

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts in Education

by
Kay L. Erland
August 1992
This Research Paper by: Kay L. Erland
Entitled: STATUS OF DIAGNOSIS OF CHILDHOOD DEPRESSION

has been approved as meeting the research paper requirements for the Degree of Master of Arts in Education.

June 23, 1992
Date Approved

Audrey L. Smith
Adviser/Director of Research Paper

June 23, 1992
Date Approved

Richard Strub
Second Reader of Research Paper

June 24, 1992
Date Received

Dale R. Jackson
Head, Department of Educational Administration and Counseling
Affective disorders in children were not recognized by professional clinicians until the beginning of the twentieth century. It was 1960 before a major textbook of psychiatry included a chapter on childhood depression (Cytryn & McKnew, 1979). To many, the idea of a child being depressed is contrary to images of childhood as a happy, carefree time (Lasko, 1986). Yet, children do show unhappy feelings in many different ways as they mature from infancy to adolescence (Epanchin, 1987). It has been estimated that 20% of the school-age population have some symptoms of depression at some time (Epstein & Cullinan, 1986).

Some mental health professionals still believe that depression as a clinical syndrome does not occur in prepubertal children because children are not psychologically developed enough to experience various symptoms of depression (Bemporad & Lee, 1988; Rie, cited in Cantwell, 1983). Lefkowitz and Burton (cited in Cantwell, 1983) proposed that many "characteristics" of childhood depression occur incidentally as part of a child's normal growth and development. Furthermore, many of these "characteristics" tend to decrease with age (Werry & Quay, cited in Leon, Kendall, & Garber, 1980).
Depression occurs at different levels of intensity, ranging from the transitory feelings of sadness that all people have at times to the more substantial symptoms that accompany clinical depression (Epanchin, 1987).

There is still controversy over specific symptoms and methods of diagnosis. However, it is now generally recognized that childhood depression does exist in a manner similar to adult depression (Kashani et al. 1981; Kaslow, Rehm, & Siegel, 1984; Kennedy, Spence, & Hensley, 1989). Furthermore, the American Psychiatric Association (APA), the accepted authority in the diagnosis of mental disorders, includes specific guidelines for the diagnosis of Major Depressive Episodes and Dysthymia in children and adolescents in its most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition Revised--DSM-III-R (1987).

The purpose of this paper is to investigate the conflicting theories of depression in school-age children and adolescents and to examine various characteristics of childhood depression with an emphasis on those proposed by the DSM-III-R (APA, 1987).
Definition of Terms

Specific diagnostic criteria for childhood depression that are listed in the DSM-III R include essential, or required, symptoms such as dysphoric mood, and other related symptoms which indicate disturbances in vegetative, cognitive, motivational and psychomotor functioning (APA, 1987; Cantwell & Baker, cited in Clarizio & Payette, 1990). Due to disagreement among the "experts", precise definitions for terms relating to depression are not easily found in the literature.

For purposes of this paper the following definitions will apply:

Depression: "emotional state characterized by extreme dejection, gloomy ruminations, feelings of worthlessness, loss of hope, and often apprehension" (Carson, Butcher, & Coleman, 1988, p. G-5).

Symptom: a sign of a pathological condition.

Syndrome: a group of symptoms that occur at the same time and represent a recognizable condition (APA, 1987).

Dysphoria: depressed or irritable mood.

Anhedonia: the loss of pleasure or interest in almost all or all usual activities and pastimes (Cantwell, 1983).
Major depressive episode: sudden condition involving dysphoria and anhedonia.

Dysthymia or Depressive Neurosis: chronic disturbance involving depressed or irritable mood (APA, 1987).

Characteristics of Depression

There is still disagreement about the actual existence of and specific symptoms of childhood depression. Clarizio (1984) stated that a clear definition is crucial in diagnosing and treating childhood depression. Lasko (1986) wrote that "a precise definition remains elusive" (p. 283). At the present time, mental health professionals follow the DSM-III-R (APA, 1987), the standard manual used to diagnose mental disorders.

The specific criteria in the DSM-III-R (APA, 1987) for assessing childhood depression have evolved from other research projects. Initially, the Washington University Psychiatric Group in St. Louis (Feighner et al., cited in Cantwell, 1983) originated the concept of diagnostic criteria for depression. This group developed a set of operational criteria for psychiatric research in adults called the Feighner criteria, so named in honor of the senior author (Cantwell, 1983).
The Feighner (1972) criteria marked the beginning point in the development of another broader set of criteria for a larger group of psychiatric disorders. These criteria are called the Research Diagnostic Criteria (RDC) (Spitzer et al., 1978). Both the Feighner criteria and the RDC were used for a research project in which the group of patients was as homogeneous as possible. Furthermore, the RDC formed the basis for the development of the DSM-III (APA, 1980) and the more recent edition, the DSM-III-R (APA, 1987), which are primarily used by clinicians with a heterogeneous group of people requiring psychiatric services. Thus the Feighner criteria and the RDC tend to be stricter criteria than the broader guidelines in the DSM-III (Cantwell, 1983).

Weinberg (cited in Cantwell, 1983) modified the Feighner (1972) criteria to develop specific criteria for diagnosing depression in children. The Weinberg (1978) criteria are divided into major and minor symptoms. The major symptoms (both must be present) are dysphoric mood and self-depreciatory ideation (Malmquist, 1983). According to Weinberg (1978) two or more of these minor symptoms must be present: aggressive behavior--quarrelsomeness,
disrespect for authority, hostility, belligerence, sudden anger; sleep disturbance; change in school performance; diminished socialization; change in attitude toward school; somatic complaints, such as non-migraine headaches, abdominal pain, or muscle aches and pains; loss of usual energy; and unusual change in appetite and/or weight (Cantwell, 1983).

The DSM-III-R (APA, 1987), under the heading Mood Disorders, discusses symptoms for two similar manifestations of depression which can occur in children—Major Depressive Episode and Dysthymia, although the boundaries are "unclear, particularly in children and adolescents" (p. 230). For the diagnosis of Major Depressive Episode, at least five of the following symptoms must be present nearly every day, for most of the day, for a period of two weeks or more: (a) depressed mood (or irritable mood in children and adolescents); (b) the loss of pleasure or interest in almost all or all activities; (c) significant weight gain or loss (in children, failure to make expected weight gains); (d) hypersomnia or insomnia; (e) psychomotor retardation or agitation; (f) loss of energy or fatigue; (g) feelings of worthlessness or inappropriate guilt; (h) decreased ability to
concentrate, indecisiveness; and (i) recurrent thoughts of death or suicide. Moreover, one of the first two symptoms—depressed or irritable mood and loss of interest and pleasure must be present.

According to the DSM-III-R (APA, 1987), the essential features of Major Depressive Episode are similar in children, adolescents and adults. However, in prepubertal children, somatic complaints, psychomotor agitation, and phobias are common. For adolescents, antisocial behavior, negativism, and the use of alcohol or illegal drugs may be present. Other possible symptoms for adolescents are grouchiness, aggression, sulkiness, withdrawal from social activities and inattention to personal appearance.

Dysthymia, or Depressive Neurosis, is a chronic condition in which the symptoms must occur for most days during a one-year period for children and adolescents (APA, 1987). For the diagnosis of Dysthymia, depressed mood (irritable mood in children and adolescents) is required. In addition, two of the following symptoms must also be present: (a) poor appetite or overeating; (b) hypersomnia or insomnia; (c) fatigue or low energy; (d) low self-esteem; (e) difficulty making decisions,
inability to concentrate; and (f) feelings of hopelessness. Children with dysthymia may react shyly or negatively to praise, and they may respond to relationships with negative behavior.

As stated earlier, the differentiation between Dysthymia and Major Depression can be unclear, especially with children and adolescents (APA, 1987). In both conditions, the symptoms may be related directly by the person or inferred by others from the person's appearance or behavior. Moreover, school performance is affected by both conditions. A main distinguishing feature between the two is that major depressive episodes are different from the person's usual functioning, whereas Dysthymia is a chronic condition which may have been the person's "normal" functioning for many years.

Diagnostic Levels

Depression may occur on at least three different levels—symptom, syndrome, and disorder (Cantwell, 1983; Clarizio, 1984; Epanchin, 1987). Each level is characterized by specific characteristics and criteria.

Epanchin (1987) wrote that occasionally everyone will experience symptoms of a depressed mood—feelings of sadness, crying spells, lack of
energy, and possible insomnia, which do not interfere with functioning for long periods of time. "Depression as a normal mood is a universal phenomenon which no one escapes" (Weissman, 1979, p. 292). These symptoms may or may not be caused by trauma or situational stressors (Epanchin, 1987), and most likely will decrease or disappear over time (Lefkowitz & Burton, cited in Clarizio, 1989).

Depression as a syndrome implies that other symptoms occur regularly with the dysphoric mood (Cantwell, 1983). Furthermore, this cluster of symptoms may include psychomotor, vegetative, cognitive and motivational disturbances as well as the affective changes linked to the dysphoric mood. The syndrome of depression may occur alone as the primary problem. It may also exist with a variety of other disorders, such as antisocial personality, anxiety disorders, etc. (Clarizio, 1984; Jacobsen, Lahey, & Strauss, 1983).

When depression is classified as a disorder there is the implication that more factors are involved than the depressive syndrome which is causing some incapacity for the person (Cantwell, 1983). Depression as a disorder involves a definite clinical description as stated in the DSM-III-R
(APA, 1987), which includes specific criteria for diagnosis, the expected course of onset and response to treatment, and an anticipated outcome (Epanchin, 1987). For a syndrome to be distinguished from a disorder, it must be demonstrated that the syndrome is not the result of a more pervasive condition, such as anxiety or personality disorders (Clarizio, 1984).

Contrasting Views of Childhood Depression

As stated earlier, some professionals believe that the type of depression known to occur in adults simply cannot and does not exist in children (Rie, cited in Cantwell, 1983). People who subscribe to this point of view are more psychodynamically oriented than other clinicians who believe that childhood depression does exist. They believe that childhood depression does not occur because children lack a well-developed and well-internalized superego. Bemporad and Lee (1988) wrote that depression in children, especially at an early age, is unlikely, due to the "great immaturity of the child" (p. 632).

Other theorists suggest that childhood depression does exist, although specific symptoms and characteristics differ (Cantwell, 1983). Some
experts agree there are many similarities between childhood and adult depression, although they believe that childhood depressive disorders have additional unique qualifying characteristics (Clarizio, 1984; Herzog & Rathbun, 1982; Kaslow et al., 1984). Cytryn and McKnew (1979) wrote that characteristics of depression in children may be expressed through fantasy, verbal expression, mood, and behavior. Moreover, the way of expressing depression may relate to the child's level of development (Poznanski, 1982).

According to Herzog and Rathburn (1982), depressed infants are usually passive and unresponsive, while a younger depressed child may be withdrawn and inhibited or impulsive and overactive. A 9-year old may be accident prone and have a poor self-image, whereas the adolescent is future-oriented and can experience hopelessness. Kovacs and Paulaniskus (cited in Bauer, 1987) wrote that less mature children show greater disruptions in sensing pleasure and are more self-deprecating while older students exhibit somatic complaints, oppositional behavior and disobedience. Also, separation anxiety is common in prepubertal children (Cantwell, 1983). Poznanski (1982) stated that
difficulty in concentrating is expressed by children through poor schoolwork, and vegetative symptoms are less prominent in children than in adults.

Unfortunately, the acceptance of special symptoms and how they are expressed varies from author to author regarding the four major diagnostic areas: mood; cognition; psychomotor; and neurovegetative. Moreover, there is not agreement among authors as to which of these symptoms are essential features of childhood depression (Clarizio, 1984; Herzog & Rathburn, 1982; Jacobsen et al., 1984; Kovacs & Beck, cited in Cantwell, 1983; Lahey, & Strauss, 1984; Lefkowitz & Tesiny, 1985).

A third group of researchers espouse the view of "masked depression"—that school age children present a variety of symptoms that hide or "mask" the underlying depression (Lesse, cited in Epanchin, 1987). These theorists believe that the major characteristics of adult depressive disorders—anhedonia and dysphoric mood—are not present in children (Cantwell, 1983). The symptoms of masked depression may include: psychosomatic complaints (Malmquist, cited in Cantwell & Carlson, 1980); disobedience; aggression; overactivity (Ling
et al., cited in Jacobsen et al., 1983); temper tantrums; enuresis; learning disability; conduct disorder (Cantwell, 1982); truancy; and aggressiveness (Epanchin, 1987).

Cantwell (1983) stated that the idea of masked depression remains questionable because: many children may have these symptoms sometime during the course of normal development; it is unclear whether these symptoms cause, are the result of, or simply coexist with certain underlying feelings and behaviors; and many of these symptoms are not distinctive enough to indicate a specific syndrome such as childhood depression. Furthermore, Clarizio and Payette (1990) wrote that subscribing to the idea of masked depression only hinders understanding of the condition and provides no clear criteria for diagnosis.

The fourth, and most recent school of thought, suggests that "if one looks for the clinical picture of depression in children in a way analogous to the way it has been looked for in adults, it can indeed be found." (Cantwell, 1983, p. 8). Bauer (1987) stated that although certain age-specific behaviors may need to be considered, the diagnostic criteria for depression is the same for children and adults.
"It is now widely recognized that children may experience a cluster of depressive symptoms similar to those found in the adult form of the disorder" (Kennedy et al., 1989, p. 561). As discussed earlier, in the DSM-III-R (APA, 1987) the main features of depression are basically the same for children, adolescents, and adults.

**Summary and Conclusions**

Childhood depression has received increasing attention by researchers and clinicians in recent years. The purpose of this study was to investigate different theories about childhood depression and to discuss various characteristics considered in the diagnosis of depression in school-age children and adolescents. Emphasis was placed on the criteria advanced by the APA in the most current edition of the DSM-III-R (1987) because this is the reference accepted by mental health professionals.

The review of literature revealed that while some experts still believe clinical depression cannot exist in childhood, due to lack of emotional development, the majority of researchers agree that the clinical syndrome of childhood depression does occur (APA, 1980, 1987; Cantwell, 1983; Clarizio, 1989; Kashani et al., 1981; Kaslow et al., 1984;
Kennedy et al., 1989). Moreover, most researchers agree that depression exists on different levels of severity—as a symptom, as a syndrome, and as a clinical disorder. The accepted guidelines currently used for the diagnosis of childhood depression are listed in the DSM-III-R (APA, 1987). This manual provides definite criteria for the diagnosis of clinical depression in children.

Further research is needed to develop specificity in the diagnostic criteria and to clarify the developmental levels of affect (Cantwell, 1982; Malmquist, 1983). The ability to more accurately define childhood depression will help professionals diagnose childhood depression earlier and to develop more effective means of treatment (Herzog & Rathbun, 1982).
References


