



“Childhood Depression: A Review Of Current Perspectives And Therapeutic Approaches.”

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Abstract: Depression is a common and important health problem affecting the lives of many children and young adults. Depression is the leading cause of health-related disability. A proportion of depression cases begin in childhood and increase dramatically during adolescence. This systematic review aimed to estimate the global prevalence of depression or depressive symptoms in children and adolescents. Depression manifests with increasing frequency as early adult life approaches and represents an escalating set of impairments across personal, family, social and educational life of children and young people. This article explain that childhood depression is a serious mood disorder causing prolonged sadness, irritability, or hopelessness that impacts a child's relationships and activities, and it is treatable with talk therapy and medication. Risk factors include genetics, adverse life events, family stress, and co-occurring conditions like anxiety

Index Terms: Lingers, sadness, child depression , mental disorder ,persistent depressive sadness.

Introduction:

Depression is the principal cause of illness and disability in the world. The World Health Organization (WHO) has been issuing warnings about this pathology for years, given that it affects over 300 million people all over the world and is characterized by a high risk of suicide.

Depression is a chronic recurrent disorder .Approximately 50% of adults with depression report their first episode of depression in adolescence .A follow up study to an acute treatment trial found that approximately 60% of adolescents experience a recurrence of their depressive disorders at 5 years. Adolescent girls were also more likely to experience a recurrence compared to adolescent boys. The prevalence of depression amongst boys and girls are similar before puberty. However, after the onset of puberty, the rates of depression amongst girls becomes 2 to 3 times higher compared to boys. Theories that have been postulated to explain this difference include significant differences in psychological factors as well as hormonal changes at puberty between boys and girls.

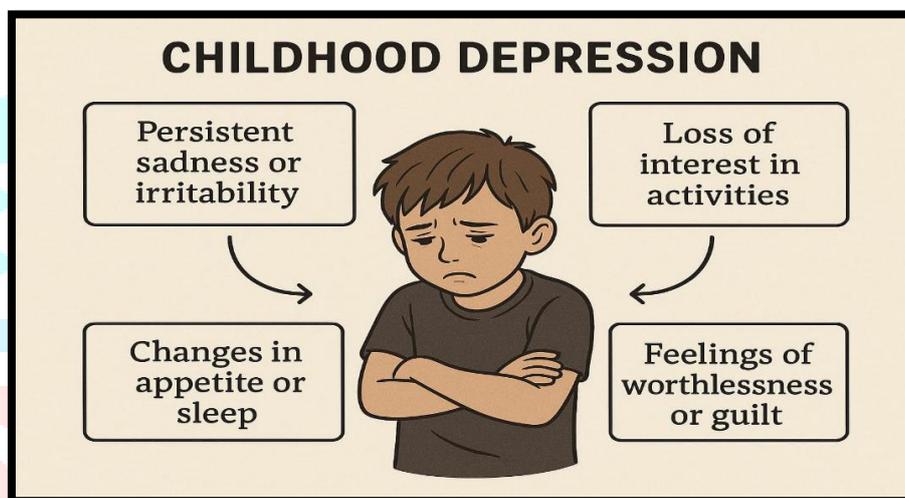
Depression and anxiety disorders can develop in children at any age, from preschool through adolescence. A combination of life experiences, inherited genes, and other factors influence who develops anxiety or depression and when. While depression and anxiety are more likely to develop in stressful situations or run in families, both can develop any time and in anyone. During the COVID-19 pandemic, rates of anxiety and depression have doubled, with depression rising to 1 in 4 children and youth and problematic anxiety to 1 in 5.If you are worried your child is thinking about self-harm, contact a health care professional immediately. Parents, teachers, and pediatric primary care clinicians can monitor for signs of depression and anxiety including school difficulties, changes in sleep or eating, getting along with friends or family.

Key symptoms:

1. Common presentations of depression in children and adolescents include: sadness and irritability, tearfulness, decreased interest, decreased pleasure in most activities, low energy, weight loss or gain, sleep disturbance including hypersomnia, difficulty with making decisions, worthlessness and hopelessness, and suicidal thinking or gesture.
2. Depression is mostly a problem of moods. Sadness or irritability is the core symptoms, and thinking, sleeping, eating, and energy are also affected.
3. Anxiety disorders are difficulties with worries or fears that make it hard for a child to participate in their day-to-day life. Extreme fears can focus on specific types of situations, such as social situations or being away from parents, or can be generalized about almost anything. Anxiety can also include panic attacks with rapid heartbeat or trouble breathing.

Depression and anxiety are treatable with therapy that teaches specific skills, medications, or both. Specific treatment plans depend on age, severity of symptoms, ability to access therapy, and family preferences.

Families can take care of your own mental health, talk about feelings starting at an early age; teach and model healthy coping strategies; keep your child safe from weapons, abuse, and preventable incidents; and talk to your child's health care professional.

**Assessment and Diagnosis:**

The clinical assessment for depression should include an interview with the patient alone and with parents/caregivers. Other sources that can provide important clinical information include teachers, extended family, community agencies (e.g., child welfare services), and any current or previous health care providers. It is important during the interview to establish rapport with the patient and to discuss the limits of confidentiality. One helpful starting point to the discussion around confidentiality is to assure patients that information will not be shared between the clinician and caregivers without the patient's knowledge and consent.

A diagnosis of major depressive disorder typically requires the presence of several symptoms, including a persistent depressed or irritable mood and a loss of interest or pleasure in activities, lasting for at least two weeks. Additionally, at least three to five other symptoms must be present, such as changes in weight or appetite, sleep disturbances, fatigue, feelings of worthlessness or guilt, diminished concentration, and recurrent thoughts of death or suicide.

Treatment:

There are two main ways to treat depression in children: talk therapy and medication. Both of these treatments may work on their own, but they seem to work better together.

Cognitive behavioral therapy (CBT):

It helps children learn to think more positively about themselves, their past and future. It is a structured, practical, and goal-oriented therapy that teaches individuals to identify negative thinking, challenge those thoughts, and replace them with healthier ones to change behaviors and reactions to life challenges.

Antidepressant medications:

Although there is much controversy about the use of antidepressants in the pediatric population, there is a substantial body of research that supports the use of antidepressants for the treatment of pediatric depression. Among the antidepressants, only SSRIs are considered first-line treatment for pediatric depression. The Food and Drug Administration (FDA) has only approved fluoxetine for the treatment of depression in children and adolescents 8 years of age and older. Escitalopram is also FDA approved for the treatment of depression but only for adolescents aged 12 and up. Fluoxetine is recommended as the first-choice SSRI. Paroxetine and sertraline are also used to treat depression.

Side effects of drugs used for treatment:

- Dry mouth
- Appetite
- Bloody poop
- Shaking
- Allergic reaction
- Fast or irregular heartbeat
- Upset stomach, nausea or diarrhea
- Sudden vision changes or eye, pain

**Combination treatment:**

There is also emerging evidence that combination treatment with antidepressant medication and psychotherapy is the most efficacious treatment. The researchers found the combination treatment group reported greater symptom reduction as well as improved satisfaction and functioning. Furthermore, they responded more quickly to treatment and had fewer instances of new onset or worsening suicidality compared to those on fluoxetine alone.

Management:

Ongoing management is critical to ensuring that children and adolescents with depression achieve remission and remain free from relapses and recurrences. If there is no improvement after 6–8 weeks with treatment, clinicians should reassess the diagnosis of depression. For example, a patient with depression who is also experiencing ongoing trauma might not respond to antidepressant treatment without psychological support. Children and adolescents with depression along with anxiety symptoms have been shown to respond better to combination treatment with antidepressant and CBT.

Conclusion:

Adolescent depression can be difficult to diagnose and needs tailored, individualized care. The prognosis of these people depends on early detection, the start of treatment, and timely referral to mental health professionals. This process may be especially difficult because of the wide range of its primary clinical manifestations and the absence of diagnostic procedures that can completely and precisely establish the definitive diagnosis. A number of differential diagnoses must also be done in order to provide a precise treatment plan. Pharmacotherapy and psychotherapy (such as cognitive behavioral therapy or IPT) are choices for treatment. The most encouraging outcomes are seen when medication, primarily fluoxetine, is combined with psychotherapy.

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