Case Report

Childhood Depression with Unremitting Suicidal Behavior

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ABSTRACT

The diagnostic criteria for major depressive disorder in adults can be applied to children and adolescents, as well, but the predominance and characteristics of symptoms in children varies widely than in adults.

Key words: Depression, Symptoms in children, Suicidal risk

INTRODUCTION

The identification of depression poses significant clinical challenges to the child psychiatrists. Clinical depression varies in the nature and intensity of its presenting symptoms. The psychiatrist should attempt to elicit as complete a picture of a child’s depressive syndrome as possible by identifying a variety of symptoms associated with this disorder and by estimating their severity.

Depressive disorders increase the risk of suicidal behavior. They are frequently associated with comorbid conditions, such as oppositional defiance disorders, conduct disorder, substance abuse disorder and anxiety disorders. They have a detrimental effect on psychological and interpersonal development. They interfere with school academic progress and with other adaptive functions. Children with depressive disorder have a significant risk of developing bipolar disorders, and added comorbid risks.

Many parents are late in recognizing depression in their children, in spite of obvious science. These parents may not realize the magnitude of depression until their child’s adaptive behavior at home and school has seriously deteriorated, until the child has expressed his desire in the form suicidal or other self destructive behaviors, or until the child has fallen victim of a devastating drug abuse problem.

ICD-10[1] and DSM-IV[2] recognize childhood depression. No distinction is made for the diagnostic criteria between pre-pubertal and adult depression. Adult diagnostic criteria are applied to diagnose these disorders in children. However, certain age-related considerations such as children and adolescents irritable mood, failure to make expected weight gains, significant weight loss or gain, change in appetite, and observations of significant others of apathy are included in the diagnostic criteria.

The clinician has to look for the cardinal symptoms of depression which include the presence of sadness or depression, anhedonia, crying, irritability, emotional withdrawal, hopelessness and associated guilt, sleep disturbances, failure to gain weight, decline in school performances, hyperactivity and associated restlessness, psychotic disturbances in the form of auditory or visual hallucinations. The unremitting suicidal ideas or attempts are the important presentation in certain children. The clinician should also take the time to rule
out anxiety or depression in the pediatric population with medically unexplained symptoms. Unexplained somatic symptom can be often considered as an indicative of a neglected depressive disorder.

Childhood depression can manifest indifferent forms such as anacritic depression, masked depression and depressive equivalents. The first study to describe a form of childhood depression with symptoms akin to adult depression was by Spitz and Wolf in 1946, who observed that infants between 6 and 11 months when separated from their primary caregiver, developed symptoms over weeks resembling adult depression and termed as anacritic depression.[3]

In masked depression, depression present is masked by other behaviors called ‘depressive equivalents’ which includes conduct problems (hyperactivity, delinquency, aggressiveness, irritability), somatic complaints (headache, stomach ache, and enuresis), school problems (school phobia, poor school performance).[4] Frommer identified three groups of childhood depression, viz enuretic depressives, phobic depressives, and pure depressives.[5]

**CASE REPORT**

Thirteen-years-old Miss X is the only child to her parents. She was brought up by her non-consanguineous parents. Both parents are employed. Parents have frequent quarrels and adjustment problems. Her maternal grandmother suffered from major depressive disorder and was treated. She is a quite active child with good intelligence with no history of delinquent or childhood neurotic traits. She is in standard VII (secondary I) in Singapore. She had emotional problems since age seven when she was in the primary level. Six years ago, she broke her ruler in anger to pieces. The triggering factor was a senior bullying her. When asked about it she said it was her father’s harsh criticisms about her study behavior and the clumsiness in the up keep of her personal belongings which made her to manifest the anger and physical aggression of breaking the ruler into pieces. There was another occasion in March 2009 when a classmate pulled off her belt and ran off. She did not react. Her non action and non aggressive nature were taken advantage by her class mates who made her very depressed. She was good in her studies averaging 70% without putting in much effort. She was keeping reasonable good physical and mental health until December 2009.

In January 2010, there was change of school since she moved to the secondary level. She started having problems coping with her school work, mainly because she was spending more time on online web chat, computer games, sending short message services (SMS) to friends and less time on studying.

It is her nature to talk freely without any inhibition. She can be called as a chatter box. At the age of 10 and at her primary IV level, she chatted with her peer group in the class room which was against the cultural norms of Singapore and she had to have counseling by the school counselor. This suppressed her spontaneity of expression and made her very quiet and non communicative though she had racing thoughts within her mind. Her self esteem hit the rock bottom. She was actually very depressed.

Her composition write up was full of references to negative events, accidents, and deaths etc. She reports that she has been having persistent suicide thought since the commencement of this academic year. There have been three instances of self injurious behaviors, when she cut her forearm just to punish herself since she felt very guilty about wasting everything that was provided by her parents. Lately she has been accepting her father’s admonitions and harsh criticisms with a resignation and having no anger reactions.

In April 2010, she sent a SMS to a friend stating that she wanted to die. In May 2010, she entered into a suicide pact with another girl who was a hysterical attention seeker. She browsed on the web for the purchase of guns and her friend informed that it was not possible to get it. This came to the knowledge of her friend’s parent who alerted the school. The school conducted an enquiry and referred her to a psychiatrist at Singapore. She was started on fluoxetine 10 mg. However, she took it only for three days and it was discontinued by her parents. For summer vacation, she came to Tamil Nadu to spend time with her grandparents. At this time, she attended Ram psychiatric hospital with her parents. Psychiatric assessment revealed that she is a child with good intelligence and academics. She was found depressed. She communicated her feelings of sadness, unhappiness and lack of interest in day-to-day activities and in general living. She consistently spoke on suicidal themes and was enquiring how to end life. She also wondered that her mother will have to go through a period of grief in the days to come and she will need to be counseled. She justified her earlier suicidal attempts and resented that she did not die. She wrote a communication note to her mother stating her to be brave, bold and not to cry if something worst happens or in the event of her death due to her self-injurious behavior and attempts to end her life. She showed a picture drawn by her and this depicted
depressing atmosphere: mostly broken eyes and angel in crucifers. Despite her depression, she was talking freely and cheerfully during this evaluation. At the time of assessment, she witnessed a string used for drying clothes and promptly expressed her to hang herself using that string. Her memory was adequate. She had no formal thought disorders or hallucinations. Her sleep was disturbed and her appetite was poor.

In clinical psychometric evaluation for arithmetic reasoning tests of BinetKamat mental ability, she performed with comfortable ease in the 14th year level test. Her intelligent quotient (IQ) was certainly over 110. Rorschach profile showed overwhelming evidence of affective dominance and color dominance. There were no indicators of schizophrenic illness in the Rorschach psycho diagnostic test.

Her physical investigations, electro encephalogram (EEG), and magnetic resonance imaging of brain (MRI) did not reveal any abnormality.

She was started on fluoxetine 20 mg and cognitive behavior therapy session. Parents were counseled and the suicide risk of Miss X was explained.

**DISCUSSION**

The case under discussion manifests with the cardinal features of sadness, irritable mood, and emotional withdrawal, hopelessness with associated guilt, and unremitting suicidal self injurious ideations and behavior.

The presence of sadness in childhood depression is a universal sign. Crying is common in children who are depressed. Akisal (1995) described two types of dysregulation of affect- a) constitutional dysregulation, b) temperament dysregulation also known as subaffective temperament. Constitutional dysregulation is an important factor in the origin of depressive affect. This starts very early in life and is manifested by irritability, temper tantrums, low tolerance for frustration, unhappiness. Temperament dysregulation refers to specific constitutionally based affective states (e.g., melancholic dysthymic, choleric-irritable, sanguinehyperthymic, cyclothymic) that are manifested predominantly at the sub clinical level. These dispositions are distressing and disruptive and are in continuum with major mood states.[6]

Marked irritability is a behavioral change that many parents observe in their depressed children. Many children identify this mood as soon as they wake up in the morning. These children are hyper active and anything can set them off. Any demand is upsetting and any expectation is too much for them. These children are prone to exhibit explosive behavior or lose control. This may lead to aggressive acting out behavior such as defiant and rebellious behaviors. This may result in exploration of potential aggressions against their self (suicidal self destructive behaviors), against others (violent and assaultive behaviors) or against the physical environment (destructiveness and vandalism).

Emotional withdrawal occurs in many depressed children. Depressed children seek solitude and withdraw from family and peer interactions. Parents report that such children do not participate in family activities or that they withdraw and refuse to be with friends.

Hopelessness and guilt needs to be identified in all the cases. Child feels that there is nothing to live for any more and may lead to unremitting suicidal behavior and may contemplate on multiple alternatives for committing suicide. The child fails to take up options presented with him, no matter how positive it may be and the response is “I don’t care” or “it doesn’t matter.

Hyperactivity, restlessness, and agitation sometimes occur in depressed children. These symptoms may be intrinsic to this disorder or may represent the expression of associated comorbid conditions, such as attention–deficit/hyperactivity disorder (ADHD), or anxiety disorders. More frequently, depressed children display slowness in psychomotor activity and in extreme cases catatonia may manifest.

The presence and the role of parents and grandparents having depression on the child’s mood disorder have been studied extensively.[7] Having a depressed mother increased the risk of psychopathology during adolescence. Grandparent’s major depressive disorder, even in the absence of major depressive disorder in the parents, was associated with an increase in internalizing symptoms in grandchildren. Major depressive disorder can have effects that persist for multiple generations. It is important for the clinician to obtain extended family history to evaluate the effect on children.[8] Studies have also shown maternal depression improvement with treatment had positive correlation and impact on children’s psychopathology.[8]

The anterior cingulate cortex has been implicated in the pathogenesis of major depression. Structurally, both postmortem and in vivo MRI studies in adult patients with major depression, including patients with childhood onset depression, have shown reduction in volume of the subgenual region of the anterior cingulated cortex.[9] White matter hyperintensities (WMH) defined as hyperintense signals on T2-weighted
MRI, classified as peri-ventricular hyperintensities (PVH) and deep white matter intensities (DWMH) had been shown to be associated with both unipolar and bipolar disorder.[10]

In EEG, certain characteristic findings have been repeatedly observed in depressed adults, like prolonged sleep latency, sleep continuity disturbances, decreased time to first rapid eye movement (REM) period, increased REM density, and decreased delta stage (stage 3 and 4). These findings are more consistent in depressed adolescents than in children.[11]

CONCLUSION

MDD is associated with severe consequences, including deterioration in academic functioning, increased risk of substance use and other mental disorders, and most critically attempted and completed suicides. Furthermore, adolescent MDD is a strong predictor of MDD in adulthood, which carries its own burden of disadvantage.

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How to cite this article: Krishnaram AV, Devendran KV. Childhood depression with unremitting suicidal behavior. Indian J Psychol Med 2010;32:146-9.

Source of Support: Nil, Conflict of Interest: None.

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