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A Short Note on Depression in Children and Adults

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INTRODUCTION

Depression in children and adolescents is common and often unrecognized. It affects 2% of prepubescent children and 5%-8% of adolescents. Evaluation should include a complete medical evaluation to rule out underlying medical causes. A structured clinical interview and various rating scales, such as the Pediatric Symptom Checklist, help determine whether a child or adolescent has depression. There are limited evidence-based treatment guidelines from the literature. Psychotherapy appears to help most children and adolescents with mild to moderate depression. Tricyclic antidepressants and selective serotonin reuptake inhibitors are limitedly studied medical therapies. The latter treatment is well tolerated but not necessarily more effective. Children and adolescents with depression are at such high risk of school truancy and suicide that they often require immediate referral or close cooperation with a psychiatrist.

DESCRIPTION

Toddlers and pre-schoolers lack the ability to verbally express their feelings of grief. Depressive symptoms should therefore be inferred from overt behaviours such as apathy, withdrawal from caregivers, developmental delay or regression, and failure to grow without an organic cause. Because psychiatric disorders in this age group are difficult to diagnose, physicians must rely heavily on parental medical histories, evaluations of parent-child interactions, and interviews by appropriately trained professionals. They can cognitively internalize social stressors family conflicts, criticism, poor performance in school and exhibit low self-esteem and excessive guilt. However, much of this inner turmoil is expressed in physical complaints headaches, stomach aches, anxiety school phobia, excessive separation anxiety, and irritability tantrums and other behavioural problems. Depression has been shown to exacerbate several HIV-related health outcomes. This is associated with a sharp decline in CD4 count and a more rapid progression to her AIDS and death. Associations with suboptimal adherence and discontinuation of Antiretroviral Therapy (ART) have been reported, significantly impacting long-term therapeutic efficacy. Adolescent depression is also associated with risky behaviour, including early sexual debut, low condom use, substance abuse, more frequent sexual partners, and unintended pregnancies. However, most evidence comes from high-income countries, with few firmly established associations in sub-Saharan Africa, the epicenter of the HIV epidemic.

Adolescents experience many developmental challenges as they strive to separate from their parents, become independent, and establish their own identity. In doing so, they become more and more dependent on their peer group. This stage of biopsychosocial maturity sets the stage for adolescents to experience greater feelings of hopelessness and hopelessness when they are more capable of committing suicide than when they were younger. They also have more anhedonia, hypersomnia, weight changes, and substance abuse than younger children. Adolescents present a particular challenge for clinicians because of their developmental struggles with the autonomy of authority figures. From the outset, clinicians should set ground rules governing when parents or other third parties are notified of what is being discussed with patients.

CONCLUSION

After recovering from a major depressive episode, many children continue to experience sequelae. Participate in assessment, diagnosis, treatment, and monitoring of risk factors, symptoms, sequelae, and recurrences solely to screen for these disorders. Lack of clinical data, limited awareness of providers and patients, and lack of resources and interventions all act as barriers to providing holistic care for adolescents living with HIV. There is an urgent need to integrate mental health into her HIV care of young people in Malawi and sub-Saharan Africa to improve their quality of life and health.

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