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Introduction

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Our knowledge of childhood depression and its origins is increasing rapidly. This account focuses on some themes emerging from recent research in consulting clinical practice concerned with over 300 consecutive referrals of children aged 9 to 16 years. A stratification procedure was employed with selection of cases for probability of childhood depression in the population concerned; we oversampled from that proportion of the population which had a potential for an excess of childhood depression.

The data gathered were used to answer some of the questions crucial to clinical practice which are outlined below.

How common is depression in a clinical sample? Previously, it was thought that depression in childhood only constituted a small proportion of the cases seen in routine practice but this did not prove to be the case.

What is the basis of the previous underdiagnosis? The main explanation is that depression coexists with other psychiatric disorders. Previously, we have tended to categorise children in a single psychiatric category, which constituted the main diagnosis, and to ignore other aspects of disturbance. However, this is an artificial solution, as often a number of disorders coexist in the same child. This is the subject of co-morbidity. For instance, one-sixth of our sample had a phobic disorder, and of these, two-thirds were also depressed; similarly, one-fifth of those with conduct disorders proved to be depressed. Thus, our findings suggest that depression may have remained undetected because of reliance upon questionable traditional systems of classification.

How useful is information obtained from interviewing mothers? In paediatric psychiatry the tendency has been to gather information from the mother alone and pay little attention to the child. But empirical research demonstrates that correspondence between parent and child is not extensive. In our study there was relatively good agreement of occurrence of symptoms between mother and child where these were potentially objectively observable, e.g. loss of appetite, loss of interest and initial insomnia. However, some features, more subjective in nature, were reported twice as often by the child as by the parent, and some (such as suicidal ideation) three times more frequently. Thus, crucially important information may not be obtainable from the mother, but from the child.

What are the implications of these findings? They confirm that there is more serious psychological distress among children seen in a psychiatric clinic than was previously thought, and that this is often not apparent to their parents; unless this is systematically and directly sought from the children and adolescents, it is likely to remain unrecognised. Secondly, they show that children and adolescents report more depressive symptoms than do their parents. As parents so often appear unaware of the true depth or intensity of their children's distress and even suicidal ideas, should we confine ourselves to interviewing children? We think not; there is good evidence that information from parents is important and useful and hence should be seen as complementary to that from the child.

The data also shed light on classification issues, particularly the distinction between factors of 'endogenous' depression and 'negative cognitions' and on the limited utility of self-report measures for diagnostic purposes. They also illustrate that some forms of prior environmental adversity have important but varying influences for different types of childhood depressions, and cast doubt on the validity of the DST as a diagnostic test for major depressive disorders in children.

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