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Depression in Asian American children

see also p 239

Danny is an 11-year-old Chinese boy with a long history of behavioral problems and academic delay. School officials referred him to the emergency department of a local hospital after he ran to a fifth floor window ledge and threatened to jump. Immediately before this episode occurred, Danny had responded to a question from the teacher in his English class by stating, "I don't know. I guess I just must be stupid."

Danny's parents are separated, and he sees his father only once every few months. When his mother, who speaks only Chinese, arrives in the emergency department, she appears tired and tearful as she struggles to hold Danny's 2-year-old sister in one arm while trying to make sure that his 5-year-old brother does not wander out of her sight. Because no Chinese-speaking interpreters are available, Danny acts as the interpreter for his mother. When asked what might have happened if he had actually jumped from the window at school, he replies, "What difference does it make?"

One of the major advances of modern day psychiatry has been the recognition that children and adolescents may develop depression and other mood disorders with con-

Summary points

- Depression may occur in Asian American children and adolescents and can be associated with significant morbidity and mortality
- Asian American families may experience cultural, linguistic, and economic barriers to accessing mental health care for depression
- Primary care clinicians who see Asian American children for "routine" or school physical examinations play a crucial role in recognizing and treating depression
- The clinician's role includes screening for warning signs of depression and suicidal risk, providing supportive initial management and follow-up, educating children and parents about depression, and determining whether specialist referral is indicated
- Referral to specialists should be considered when symptoms are severe or when mild symptoms do not remit after a brief course of supportive management

stellations of symptoms similar to those found in adults.[1-4] Little is available in the literature to guide parents, primary care clinicians, educators, or mental health providers on features that may be specific to the diagnosis and treatment of mood disorders in Asian American youth.

Available evidence suggests the following:

- Asian Americans are less likely than whites to use mental health services[5]
- Suicide rates in Asian American adolescents and young adults are higher than in white youth and young adults[6]
- The prevalence rate of depressive diagnoses in adolescence is different in Asian Americans from that in whites. This diagnosis is less likely in Asian American boys than in white boys, whereas depression is more prevalent in Asian American girls than in white girls[7]
- Asian Americans are vulnerable to posttraumatic stress disorders and depression associated with adverse experiences in their country of origin[8,9]

BARRIERS TO CARE

Problems experienced by Asian Americans in accessing health care, especially mental health services, include cultural and linguistic barriers, stigma associated with psychiatric disorders, availability of appropriate staff, and lack of adequate insurance coverage.[10] Primary care clinicians to whom Asian American parents bring their children for "routine" or school-related check-ups may provide the only opportunity to identify debilitating depressive symptoms.

The crucial roles of such clinicians include overcoming barriers to recognition of depression (box 1), assessing the presence and severity of depressive symptoms and suicidal risk, determining when referral for psychiatric evaluation is indicated, and collaborating with psychiatrists and other mental health providers in effective management strategies.

Box 1 How to overcome barriers to recognizing depression

- Increase awareness of risk of depression and its symptoms
- Ensure availability of culturally and linguistically competent clinical staff
- Focus on helping family members to find culturally acceptable ways of discussing uncomfortable thoughts and feelings

DEPRESSIVE DISORDERS IN CHILDREN

Depression refers to transitory or persistent disturbances of mood that may occur from childhood through old age. Depressive disorders are specific constellations of emotional, cognitive, and behavioral symptoms that also may occur across the age spectrum. Depression may be found in association with a variety of other psychiatric and medical disorders.[11]

A description of these disorders in adults begins on p 239.[12] The diagnostic criteria for depressive disorders in children have modifications that allow for developmental variations in presentation,[1-4] but not for variations related to ethnicity. These modifications permit the substitution of irritability for depressed mood, duration of 1 year instead of 2 years for dysthymic disorder, and failure to make expected gains in weight or academic performance rather than decline from previous levels.[4]

The estimated prevalence of depressive disorders is 2% in children and 5% in adolescents.[1-3] This rate may be considerably higher in pediatric patients with medical or neurologic illnesses.[13,14] Depressive disorders are associated with major impairments in social, academic, and emotional functioning that may persist after the resolution of the depressive episode.[15] They are also associated with an increased risk of suicide[15,16] and self-injurious behaviors that may result in chronic physical disability. Children and adolescents who experience depressive disorders are at significantly increased risk for recurrence.[15,17,18]

ASSESSMENT AND EVALUATION

In view of the substantial morbidity and potential mortality associated with depressive disorders, screening for warning signs suggestive of depression (box 2) should be considered as part of the general pediatric evaluation of

Matt Bridger/DHD Photo Gallery

Asking children about their mood must account for their cultural and linguistic background

every child from age 5 or 6 years. It may readily be incorporated into the history, review of systems, and physical examination.[11]

Parents and children may differ significantly in their reports of emotional and behavioral problems. Children tend to provide more reliable information about their emotional states than about their behavior. Parents on the other hand give more reliable information about their children's behavioral rather than emotional problems.[19] Therefore, it is important to ask children or adolescents directly about their emotional state. Such inquiries (box 3) should be made with special attention to the age, developmental state, and cultural and linguistic background of the child.[19]

Careful and direct inquiry is especially critical for Asian immigrant children who may be the only English-speaking member of the family. The role of children and adolescents as "cultural brokers" for immigrant or less acculturated families is a major factor resulting in psychological stress. Asian boys and girls are often asked to interpret the concerns of adult family members to outside authority figures, such as teachers, doctors, and government officials. This burden confers responsibility for many youths before they are able to navigate their own pressures of "fitting in," adopting Western values while retaining Asian ones at the urging of parents, and maintaining high academic or work standards, including working outside and inside the home.

Box 2 Warning signs of depression

- Persistent sad or irritable mood
- Changes in energy, sleep, or appetite
- Unexplained declines in academic performance
- Negative statements about self
- Suicidal statements or behaviors

Box 3 Questions to ask children to assess their mood

- It can be helpful to begin with an open-ended question: "How are you feeling?"
- If the response is noncommittal or without elaboration ("I don't know" or "ok"), consider offering choices such as "happy," "sad," "down"
- In younger children or children with whom there is a language barrier, consider using drawings of faces with upturned or downturned lips or tears to indicate sadness
- Ask for clarification if the child or adolescent describes him- or herself as depressed (ie "what does this word mean to you?")

In the case example, Danny must provide information about his own problems while taking the "responsible" role of navigating his family's needs. The stresses involved in this double role may be contributing factors to his depression. The availability of trained interpreters to assist in separate interviews with monolingual parents can help to alleviate this burden on the child and allows parent and child the opportunity to speak more freely about their concerns without the other being present.

Children and adolescents who are reported to have made suicidal statements, have engaged in potentially self-injurious behaviors, or exhibit other warning signs of depression should be asked specifically about suicidal ideation and intent.[16]

When screening elicits findings suggestive of a depressive disorder, it is important to educate pediatric and adolescent patients and their parents about the short- and long-term suffering and impairment in functioning associated with such disorders, the risk of suicide and other self-injurious behaviors, and the availability of effective treatment options.

Primary care clinicians should also maintain a high index of suspicion for anxiety disorders and other emotional and behavioral problems, the reported prevalence of which is high in depressed children and adolescents.[20,21] Assessment should include inquiries about the family's previous efforts to manage emotional and behavioral problems in the child or adolescent, including possible use of herbal remedies or other nonprescription medications.

REFERRAL TO A MENTAL HEALTH SPECIALIST

The primary care clinician who observes signs and symptoms suggestive of depression in a child or adolescent must

Box 4 Indications for emergency psychiatric referral

- Suicidal statements ("I want to die," "I want to kill myself")
- Suicidal threats or plans (eg, overdose; jumping from high places; suffocating, shooting, or cutting oneself; walking into traffic)
- Self-injurious or suicidal behaviors
- Psychotic symptoms (hallucinations, delusions)
- Combination of any of the above with hopelessness, substance abuse, lack of family support, access to weapons

make two immediate management decisions. The first is whether the patient's symptoms and behaviors constitute an acutely life-threatening crisis that requires emergency psychiatric evaluation and possible psychiatric hospitalization (box 4). The second decision is whether an initial course of supportive medical management is adequate to address the patient's depressive symptoms or is referral for timely but not emergent psychiatric evaluation indicated (box 5).

Close and ongoing collaboration with the patients' parents or legal guardians is integral to choosing the best course of action. In this collaboration, the primary care practitioners should emphasize that the best outcomes can only be achieved with the active involvement of parents and significant loved ones. Particularly with Asian parents who place a high value on education, stressing the effect that depression may have on academic achievement encourages parental acceptance of psychiatric referral and treatment.

MANAGEMENT

Effective management of depression requires a comprehensive approach to underlying environmental, psychological, and biologic factors; clear formulation of goals (box 6); and knowledge of recommended treatment guidelines for depression in children and adolescents.[3]

Box 5 Indications for timely (but not emergency) psychiatric referral

- Persistent mild to moderate depressive symptoms associated with impairments in social or academic functioning that do not respond to initial supportive measures
- Past history of depressive episodes
- Consultation regarding need for specific psychological or pharmacological interventions

Box 6 Depression in children: management goals

- Alleviate suffering associated with depressive symptoms
- Alleviate environmental stressors
- Reduce risk of suicide and other complications
- Improve social and academic functioning
- Identify and treat associated medical conditions

Supportive management, including relief of minor medical conditions; reduction of environmental stressors; and offering the child and family the opportunity to express their concerns, may be sufficient to alleviate mild and transitory depressive symptoms. More specific psychological and pharmacologic treatments should be considered for serious and persistent depressive symptoms that are associated with impairments in social and academic functioning.

Current evidence and clinical experience suggest that many children and adolescents with depressive disorders respond favorably to specific types of psychotherapeutic interventions, such as cognitive-behavioral therapy, interpersonal psychotherapy, and antidepressant medication.[3] Unfortunately, the knowledge base about the safety and effectiveness of pharmacologic treatments of depression in children and adolescents is limited. In addition, the potential for interactions between antidepressants and other prescribed medications and nonprescription remedies must be considered. Given all of these limitations, together with the absence of systematic data on the treatment of depression in Asian American children, primary care clinicians are advised to seek psychiatric consultation for a depressed child or adolescent before selecting a particular form of treatment.

Warning signs of depression include Danny's sadness, irritability, negative self-image, and suicidal threats and behaviors. Environmental stressors include his problems at school, the fragmentation and economic disadvantage of his family, and his mother's possible depressive disorder. Barriers to care include the absence of linguistically competent staff to assist in interviewing his mother and helping her to cope effectively in an unfamiliar setting.

Emergency psychiatric referral is indicated to assess the following: suicidal risk, severity of depressive symptoms, possibility of other emotional and psychiatric disorders, need for

psychiatric hospitalization, and indications for specific psychological or pharmacologic interventions. Referral for social service evaluation for Danny's mother is indicated. This referral would allow professional assessment of the availability of family, friends, and public resources to help alleviate the stress she is experiencing in caring for her children and the potential benefit of psychiatric or psychosocial intervention for her own depressive symptoms. Gaining collateral information from Danny's school is indicated to determine the need for a psychoeducational evaluation to assess for learning disorders and to develop a plan to help him with his academic difficulties.

Current experience suggests that Danny's depressive symptoms may respond favorably to available treatments but that Danny is at risk for recurrence after remission of the present episode.

Danny's case illustrates common themes that may occur in the presentation of children with depressive symptoms. It also illustrates cultural and linguistic barriers that may affect the evaluation and treatment of children from Asian American and other non-English-speaking backgrounds. As for other conditions that may remit and relapse in childhood, adolescence, and into adulthood, the role of the primary care clinician encompasses not only initial recognition and specialist referral but also periodic monitoring to provide early identification and intervention in case of recurrence. This role takes on special importance in the care of children from Asian American families. These families may be wary of psychiatrists and other mental health professionals but are more accepting of the need for occasional medical visits for somatic complaints or annual physical examinations required by schools.

Box 7 Suggestions for further reading

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