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DEPRESSION IN EARLY CHILDHOOD

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SUMMARY

According to data from the WHO, the Covid-19 pandemic has created an increase in anxiety and depression around the world. In particular, there has been an increase in Depressive Disorder in childhood: the closure of childcare centers has caused great stress in parents, especially in mothers who have developed more depressive disorders. Maternal depression appears to have created problematic behaviors in preschool children. This phenomenon is explained by several studies that over the years have shown that a good mother-child interaction is essential for the child's psychophysical health and that interactions with depressed mothers have caused depression in children already in early childhood.

The purpose of this work is a review of the scientific literature, from 1927 to 2022, on depression in early childhood, from 0 to 5 years of age. Research has been carried out on Medline PubMed, Google Scholar and specialist scientific journals of psychiatry, psychology and child neuropsychiatry, using the following keywords: infant depression, anaclitic depression, hospitalism, early chilhood depression, depressive position, attachement and mother-infant dyad.

The depressive illness of the mother, the lack of care, attention and stimulation to the vocalizations of the young child can induce negative reactions in the relationship between mother and child. Early identification and treatment of perinatal depression is critical to ensuring the child's optimal development and future mental health. In addition to maternal depression there are also other factors that can generate depression in the child as well as a prolonged separation from her.

The authors' conclusions are that it is essential to train and inform educators and family members on depression in childhood to allow for the recognition of the child's suffering and for it to be examined by the doctor. It is important an early intervention both on the family and on the child to avoid relapses, chronicity and any serious damage.

Key words: *infant depression - anaclitic depression – hospitalism - early childhood depression - depressive position - attachement e mother-infant dyad*

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INTRODUCTION

Depression in childhood is the most common mental pathology in man's developmental age group. For a long time it was not evaluated as a real disease. Only in the last 10 years mental health and development communities have generally accepted that depression can arise in early childhood (Luby & Whalen 2019). It was believed that young children were too immature to experience the main emotions of depression, thus ruling out the possibility of clinical depression before school age (Rie 1966). Depression was often confused with the typical behavioral and relationship difficulties of the childhood phase of human development. The child is rarely able to express his feelings and emotions verbally. Furthermore, in minors, depression takes on very different characteristics from those presents in adults. In children joyful and lively behaviors hide and mask depressive characteristics.

WHO with a press release, dated March 2, 2022, announces that the COVID-19 pandemic has triggered a 25% increase in the prevalence of anxiety and depression worldwide. WHO calls on all countries to enhance mental health services and support. The World Health Organization indicates the following frequencies of Depressive Disorder in the developmental age: 0.3-1% in preschool age; 0.4-2.5% in school age; 4-8.3% in adolescence. During this period of the COVID-19 pandemic where depression and anxiety are increasing, parents are preoccupied with both health and financial worries. For families with preschoolar children, the prolonged closure of childcare centers places an additional childcare burden on family members, particularly mothers. The mother's increased COVID-19 stress has been associated with increased depression and a progressive decrease in positive parenting behaviors, factors that in turn led to problematic behaviors of preschoolar children (Yoo & Lee 2022). The interaction disorders of depressed mothers with their babies appear to be universal, across different cultures and socioeconomic status groups, and include lower sensitivity of mothers and children's responsiveness (Field 2020).

Historical background

We have to wait for the studies of Kraepelin, German psychiatrist and psychologist, father of modern psychiatry, to frame Melancholy as a phase of Depressive Mania (Kraepelin 1921). Melanie Klein, Austrian psychoanalyst, pioneer of child psychoanalysis, highlighted childhood depression in 3-4 year old children. After a long period of observation, she formulated the theory of the "depressive position" during the development of affectivity and the mother-child relationship, already in the very early stages of life

(Klein 1927). The depressive position coincides with weaning. The child discovers that he is dependent on his mother for his own vital needs and at the same time feels helpless because he cannot always have her with him. He therefore develops a depressive attitude. It may or may not be overcome.

Subsequently, the observations and studies of the Austrian psychoanalyst René Spitz on "anaclitic depression" (from the Greek anáklitos, lying back, supine) highlighted how childhood depression can manifest itself already after the first six months of a newborn's life. It arises as a reaction to a prolonged separation from her mother and her loving care (Spitz 1945).

In the following years, scientific research has better framed childhood depression from the relational and behavioral difficulties of the child's development. It distinguishes it from the same relationship difficulties, from autism, from intellectual disabilities, from the attention deficit / hyperactivity syndrome and from learning disorders. It differentiates major depression from bipolar disorder, persistent depression and disruptive mood dysregulation (DSM-5 2013).

SUBJECTS AND METHODS

The purpose of this work is to review the scientific literature on childhood depression, focusing on early childhood from birth to preschool. Evaluate the clinical, symptomatic, diagnostic, therapeutic and historical aspects, updated to modern times. Research has been carried out on Medline PubMed, Google Scholar and specialist scientific journals of child psychiatry, psychology and neuropsychiatry, from 1921 to 2022, with the following keywords: depression infant, anaclitic depression, hospitalism, depression early chilhood, depressive position, attachement and mother-infant dyad.

RISULTS

Children of depressed mothers

According to a recent systematic review and meta-analysis published in JAMA Network Open, up to 3.18% of couples, both mothers and fathers, suffer from perinatal depression. Kara L. Smythe et al, of University College of London conducted a systematic review of the literature to identify studies evaluating the prevalence of perinatal mood disorders in both mothers and fathers. From the 23 studies identified (29,286 couples), the researchers found that the overall prevalence of prenatal depression in both parents was 1.72%. Prevalence ranged from 2.37% for early postnatal depression (up to 12 weeks after delivery) to 3.18% for late postnatal depression (3 to 12 months after delivery) (Smythe et al. 2022).

The depressive illness of the mother, the lack of care, attention and stimulation to the vocalizations of the young child can induce negative reactions in the relationship between mother and child. The expressionless, apathetic and immobile face of a depressed mother can cause negative mood in the child, also affecting relationships with others (Tronick 2009). On the other hand, positive responses to the smiles of the newborn, on the mother's face, restore emotional vitality to the infant.

According to Goodman JH addressing the potential effect of maternal depression on the infant may require interventions focused on the mother-infant relationship and dyadic interaction. Early identification and treatment of perinatal depression is critical to ensuring the child's optimal development and future mental health (Goodman 2019).

Goodman JH highlighted in his work “Perinatal depression and infant mental health” that: a) the mental health of the newborn and early childhood is inextricably intertwined with and influenced by maternal mental health. b) Perinatal depression is associated with an increased risk of the child's emotional problems which may persist into young adulthood. c) Early intervention in perinatal depression can prevent mental health problems related to children, adolescents and adults (Goodman 2019).

Farah R et al. show that maternal depression is characterized by a lack of emotional responsiveness and involvement with the child. It can lead to a decrease in the child's cognitive and linguistic outcomes, all of which are related to the child's future reading ability. The relationships between maternal depression and functional connectivity in the neural circuits that support language in the child were explored (Farah et al. 2021).

Research results by Urizar jr GG and Muñoz RF suggest that maternal depression experienced during pregnancy has long-term negative effects on the baby's cognitive development up to 5 years after delivery, particularly among girls. Furthermore, both the timing (pregnancy and early postpartum) and the severity / chronicity of maternal depression are independently associated with the socio-emotional development of the child in the low-income sample they examined (Urizar jr & Muñoz 2022).

From the first day after birth, babies have the ability to connect with the social world around them. They express their social and relational skills through motor skills, facial expressions, sucking, eye contact, vocalization and the ability to attract the attention of others (De Rosa et al. 2010, Guedeney et al. 2012).

Attachment is an established and developed pattern of interaction and communication between mother and baby. For the growth of mentally and physically healthy people, the mother is expected to create an

adequate attachment starting from before birth and maintain it thereafter. It is also necessary for the baby to establish an appropriate and secure attachment to the mother in a similar way. There are several factors that influence attachment. Furthermore, some studies show that children with attachment problems also have problems in their future lives (Karakaş & Dağlı 2020).

The relationship between maternal depression and attachment to the child is complex and dynamic, and the possible negative effects of depression could be offset by maternal involvement in childcare (Sliwerski et al. 2020).

Anaclitic depression

Anaclitic depression was first described in a 1945 newspaper article by René Spitz. In 1946 he described his study of him on 123 children between 6 and 8 months who had been separated from their mother for 3 months. After about 6 months of age, the previously happy babies became crybabies and then withdrew, refusing to interact with the people around them. At first they cried or screamed when urged to commit, but after about 3 months they became so numb that even the crying and screaming stopped. Some of the children had lost weight, had not slept well, and were more susceptible to colds or eczema. Gradually, their general development decreased. Symptoms of anaclitic depression are similar to those of depression. Symptoms include: a) anxiety, sadness and crying, b) withdrawal into oneself and refusal to interact with the environment; c) impediments to development, including a slow reaction to stimuli and slow movements; d) loss of appetite and weight loss; e) insomnia; f) frozen and emotionless facial expression (Spitz & Wolf 1946).

Anaclitic depression appears to resolve and with a positive prognosis when the child and the mother or primary caregiver reunite. When the mother and baby were together again, the baby quickly became happy and interactive. In addition to this notable change, Spitz has in some cases measured a marked leap in the child's development. In a second institution, however, in which children who had been separated from their mothers were not reunited with her, Spitz described a progressive syndrome, which, after the 3-month developmental critical point, became irreversible and even led to to the death of almost a third of the children.

“In the first three months the child's experiences are exclusively of an emotional nature; the sensory, the ability to discriminate, the perceptual apparatus are not yet developed from a psychological point of view and perhaps not even from a physical point of view. So it is the affective attitude of the mother that serves as guidance for the infant. [...] It can be objected that the mother is not the only human being around the child, that there are also the father, the brothers, the sisters who logically have their importance. In addition, the cultural environment also has its value, even in the first year. This is an undeniable fact; yet in our Western civilization all these influences reach the child through the mother or her substitute. [...] In the mother-child relationship, the mother represents the environmental factor or, if you prefer, it can be said that the mother represents the environment. Contrasted to this factor is the child's congenital kit […] The two interacting factors are therefore the mother, with her individuality already formed, and the child with an individuality in the process of being formed. The two elements mother and child do not live in a vacuum, but in an economic-social environment, in which family members are the primary determining factors, while the group, culture, nation, historical epoch and tradition are factors. to a wider range." (Spitz 1972).

Spitz defined "hospitalism" (or "hospitalism", from the original English term "hospitalism") that disorder that occurs in children who have never had any relationship with their mothers or with an equivalent figure, or have had it only for a few days or weeks; "Anaclitic depression" when the child has lost this relationship after a few months of life, for example in case of death or prolonged absence of the mother.

"Anaclitic" comes from the Greek anaklino, which means "to lean on" or "to support oneself on something", and it had already been used by Freud to indicate the initial stage of life, from birth to six months, in which the newborn is totally dependent on the mother. not yet being able to distinguish himself from her. Spitz wants to highlight with this term the emotional support that the child seeks in the mother or in the person who takes care of him the most.

A recent Moroccan study found that social withdrawal behavior in infants is a key indicator of childhood distress and a risk factor for subsequent illnesses. The authors used the Alarm Distress Baby (ADBB) rating scale applied to two very different populations in terms of early separation experiences: a cohort of 56 children living in a children's home and 56 children raised by their families, as a group. control. These 102 children were assessed using the ADBB scale during routine pediatric follow-up between the ages of 2 and 18 months. Withdrawal behavior was significantly more marked among children raised in a children's home than children raised by their family, and was more pronounced among boys than among girls. This study, including the control group, confirmed the validity of Spitz's description, which placed social withdrawal at the center of anaclitic depression and the causes of hospitalization, and attributing this withdrawal to the early and prolonged separation of children from their caregivers. The authors recommend using the same ADBB rating scale for systematic detection during routine pediatric checkups or for the follow-up of at-risk children, to allow for appropriate early interventions (Chkirate et al. 2021).

The causes of childhood depression

Multiple causative factors are considered for childhood depression. Causes of biological, psychological and social origin, as well as a family predisposition. Depression is not an inherited disease, but there may be a genetic vulnerability of children of depressed parents and greater ease of illness, with acute onset and longer duration of the disease (Nixon 1999). Studies on monozygotic twins have shown agreement values equal to 65%, while in dizygotic twins these values are around 15% (Militerni 2004).

Stressors have a neurobiological impact on the nervous system and on the regulation of chemical transmitters such as serotonin, noradrenaline and dopamine. Social causes, difficulties in the family, at school and between peers, reduced and unmotivated interpersonal relationships contribute to the disease. The dyadic mother-child relationship is decisive, a lack of care, attention, lack of empathy, the depression of the mother or both parents, the absence of the maternal figure or the primary caregiver can induce severe emotional deficiency and a depressive reaction in the child, especially in the first months of life.

Symptoms of early childhood depression

Symptoms may vary in relation to age and the ways of responding and reacting to depressive illness.

Depression in the first years of life (<3 years) there are both physical and psychological symptoms such as: alterations in eating habits with lack of appetite and / or refusal of food • impaired motor skills (slowing down or restlessness) • psychomotor delay or regression • irritability, excessive crying • sleep disturbances • psychosomatic disorders (vomiting, diarrhea, asthma, dermatitis, alopecia, etc.) • difficulty in reaching the expected weight for age • poor eye contact • reduced facial expression • absence of social smile • lack of curiosity , poor exploration • little interest in play • self / heteroaggressiveness, closure and inability to respond to social stimuli that can lead to anaclitic depression and hospitality in hospitalized children without affective care.

Depression in early childhood (from 3 to 5 years old) subjective and behavioral depressive symptoms are very often present such as: a) sad, melancholic or even dysphoric mood and emotional lability, anhedonia; b) irritability, aggression, anger, lack of esteem, feelings of guilt; c) frequently there are anxiety disorders, separation anxiety and school phobia; d) sleep and appetite disorders; e) oppositional or avoidant attitude, with self-closure and little socialization; f) behavioral disturbances, school and relational difficulties. The child may have a very close and regressive bond with the mother with typical symptoms of separation anxiety. There may be feelings of inadequacy and inferiority, insecurity, low tolerance for frustration.

In this age group, children with Major Depressive Disorder in addition to the above symptoms may present: a) somatic complaints (vomiting, asthma, dermatitis, allergies, abdominal pain, headache, alopecia), enuresis and / or encopresis, sleep disturbances with difficulty falling asleep, frequent nightmares and night terrors, alterations in eating behavior (including coprophagia or pica), weight changes and difficulty in reaching the expected weight for age, reduced motor activity and excessive fatigue. Furthermore, depressed preschoolers may lose skills already acquired in various fields (motor, linguistic, cognitive, sphincter control). The little one appears shy, withdrawn, embarrassed, he prefers to be alone or with adults.

Preschool children with Dysthymic Disorder appear very sad and / or irritable, their facial expressions and eye contact are poor, their affect is flattened. They do not show pleasure in the game, they have behaviors of social withdrawal, poor verbal communication, poor reactivity; the level of motor activity can be low (slowing), but also sometimes abnormally high (hyperkinesis). Poor appetite, sleep problems and, sometimes, even slowed physical development are common. They are better able to report feelings of feeling unloved, loss of hope, somatic complaints, anxieties, worries and concentration difficulties (SINPIA guidelines 2007).

Among the depressive disorders, the diagnosis of Disruptive Mood Dysregulation Disorder is not placed before the age of six or after the age of 18. It is characterized by severe and recurrent outbursts of anger, both verbal and physical, aggression disproportionate to the intensity and duration of the situation or provocation and with a frequency of 3 or more episodes per week. The mood, between one outbreak of anger and the next, is mainly irritable and angry. Symptoms must last for at least 12 months and occur at home at school and among peers and must not present during an episode of Major Depression. Bipolar disorder usually onset in adulthood or late adolescence. Cyclothymic Disorder occurs in adolescence and early adulthood (DSM-5 2013).

Symptomatic comparison between depression in children and adults

The symptoms that occur in the child as a defense against the depressive position can be: a) turbulent behavior, both motor and psychic instability (manic defenses as to deny or to overcome any depressive aspect). b) Conduct of opposition, anger, rage, aggressive manifestations (clastic crises, violence with peers). c) Behavioral disturbances (thefts, escapes, criminal conduct). d) Conduct of protest or claim in the face of the state of suffering.

Symptoms directly related to depressive illness (similar to those of adults)

Intense prostration, withdrawal, isolation, motor inhibition, difficulty playing, sad appearance, crying, boredom, indifference. Self-depreciation: “I don't know”, “I'm not capable”, “I can't”. Difficulty concentrating and memorizing.

Symptoms related to depressive affect (they are the most frequent and move away from adult semiology)

Excessive docility, passivity, submission to the adult. School failure. Phobic behavior, unkempt, sloppy appearance. Repeated injuries, frequent punishment, dangerous attitudes, self-aggressive conduct (direct evidence of a feeling of guilt or a need for punishment).

The younger the subjects are, the more difficult they have to describe their state of mind and often confuse emotions with each other, such as anger and sadness, and try to communicate their discomfort through abnormal behaviors. It is not uncommon in clinical practice to find young people who manifest deep feelings of depression not recognized either by their parents or by other informants such as, for example, teachers. Although, therefore, news from different life environments can be collected in young subjects, a diagnostic clarification is achieved only in a direct relationship with the child or adolescent according to the most facilitating methods in relation to age (play, drawing, interview, etc.) (Guareschi Cazzullo 2001).

Suicide and preschool suicidal ideation

In the literature there is little work on suicide and suicidal ideation in preschool (<5 years), perhaps due to the difficulty of finding data or the tendency to evaluate the nefarious episode as an accident or fatality. Even in the official reports of the Web-based Injury Statistics Query and Reporting System (WISQARS) of the Centers for Disease Control and Prevention in the United States and the WHO, data start from 5 years of age and are few in number in childhood depression.

It's easy to think that when preschoolers talk about wanting to die and about suicide, they don't understand the concept of death. A recent study by Hennefield A et al. highlights how children aged 4-6 who express suicidal thoughts and behaviors have a better understanding than their peers of what it means to die. Therefore, such thoughts of death should always be taken seriously (Hennefield et al. 2019).

Diagnosis of childhood depression

For the diagnosis of Major Depression in childhood as well as that of adults, according to DSM-5, five symptoms described above must be present for at least two weeks, which compromise the patient's normal daily and school activity. and that they are not secondary to other pathologies (DSM-5 2013).

The greatest difficulty in diagnosing Major Depression in childhood consists precisely in the different way of presenting the symptoms compared to the typical pathology in adults. In it there are sad moods, negative feelings, pessimism, feelings of guilt, a tendency to cry, lack of strength, sleep and appetite disorders, low activity and social withdrawal.

On the contrary, as we have seen, childhood depression has behavioral symptoms of strong reactivity to depressed mood. Finally, excessive docility, sustained passivity and marked submission to the adult can also conceal a depression in childhood. Very quiet children in the classroom, isolated, very obedient, closed, introverted children, teenagers in line as good soldiers can mislead the diagnosis. Upon careful examination, these behaviors could reveal an underlying depressive pathology. In Persistent Depressive Disorder (formerly dysthymic disorder), a chronic form of depression, the symptoms must be persistent for one year. This new diagnosis of the DSM-5 includes the diagnostic categories of chronic major depression and dysthymia of the DSM-IV.

Therapy

Individual and group psychotherapy, in particular Cognitive Behavioral Therapy and Interpersonal Psychotherapy are commonly used in mild and medium severity forms for childhood depression. Behavioral Cognitive is a treatment documented by many scientific researches, the second is a promising intervention in adolescents.

Drug therapy is used in the most severe or risky forms of depression in childhood in combination or not with psychotherapy. Tricyclic antidepressants are little used both because they are not very effective and because of their side effects. Mostly serotonergic antidepressants are used. However, it is necessary to be very careful in prescribing antidepressants in early childhood, both for side effects and for the possibility of excessive behavioral activation, and for possible suicidal ideation and self-harm behaviors.

When social causes and circumstances of daily life are prevalent, it is necessary to intervene to provide adequate interventions also in the family, such as counseling and psychoeducational support therapy to parents and primary caregivers (SIMPIA 2019).

Recent research, carried out by Washington University School of Medicine in St. Louis, by Luby JL et al. demonstrated that mother-child dyadic interactive psychotherapy (PCIT-ED) involving depressed parents and children aged 3-6 years can reduce depression rates and symptom severity. The authors adapted a

treatment known as Parent-Child Interaction Therapy (PCIT), developed in the 1970s to treat disruptive behavior in preschool children. Sessions focused on emotions have been added to this treatment. Indeed, the authors conceptualize depression as an impairment of the ability to experience and regulate emotions. The goal of the treatment program is to improve the child's emotional development. One of the ways to achieve this is to teach parents how to manage the child's emotional responses to certain stressful situations. The authors noted that the symptoms of depression not only improved in the children, but also improved in the parents who worked with their children during the study (Luby et al. 2018).

CONCLUSIONS

Training and information work for educators and family members on depression in early childhood is essential to allow the child's suffering and social dysfunction to be recognized and to have it examined by the doctor. A prompt diagnosis and treatment by the specialist is necessary, also to avoid the possible serious consequences and risk factors associated with a lack of therapy. An early onset of depression, in addition to being a source of suffering for the child and his / her parents, can create the conditions for relapses in later years, adolescence and adulthood if it is not treated properly (Luby et al. 2014). Self-harm, suicidal behavior and drug addiction and alcohol abuse can have disastrous consequences for the patient and his family.

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Maurilio Giuseppe Maria Tavormina & Romina Tavormina carried out literature search and wrote the paper.

Maurilio Giuseppe Maria Tavormina conceived the idea of the paper, reviewed the literature and wrote the final draft.

Romina Tavormina reviewed the literature and contributed to the final draft in English.

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